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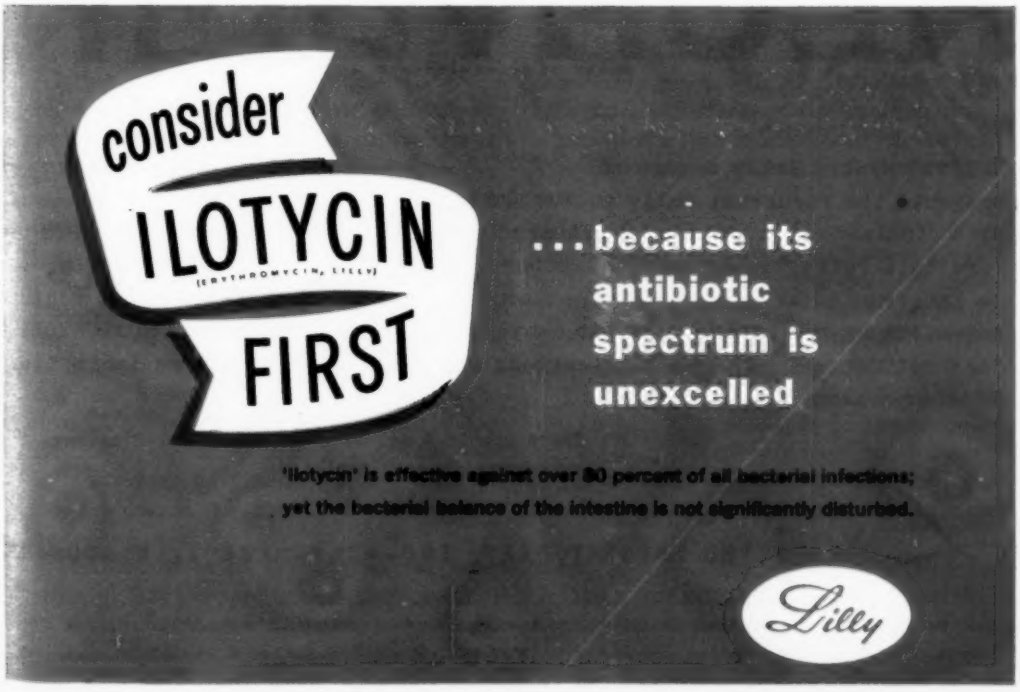

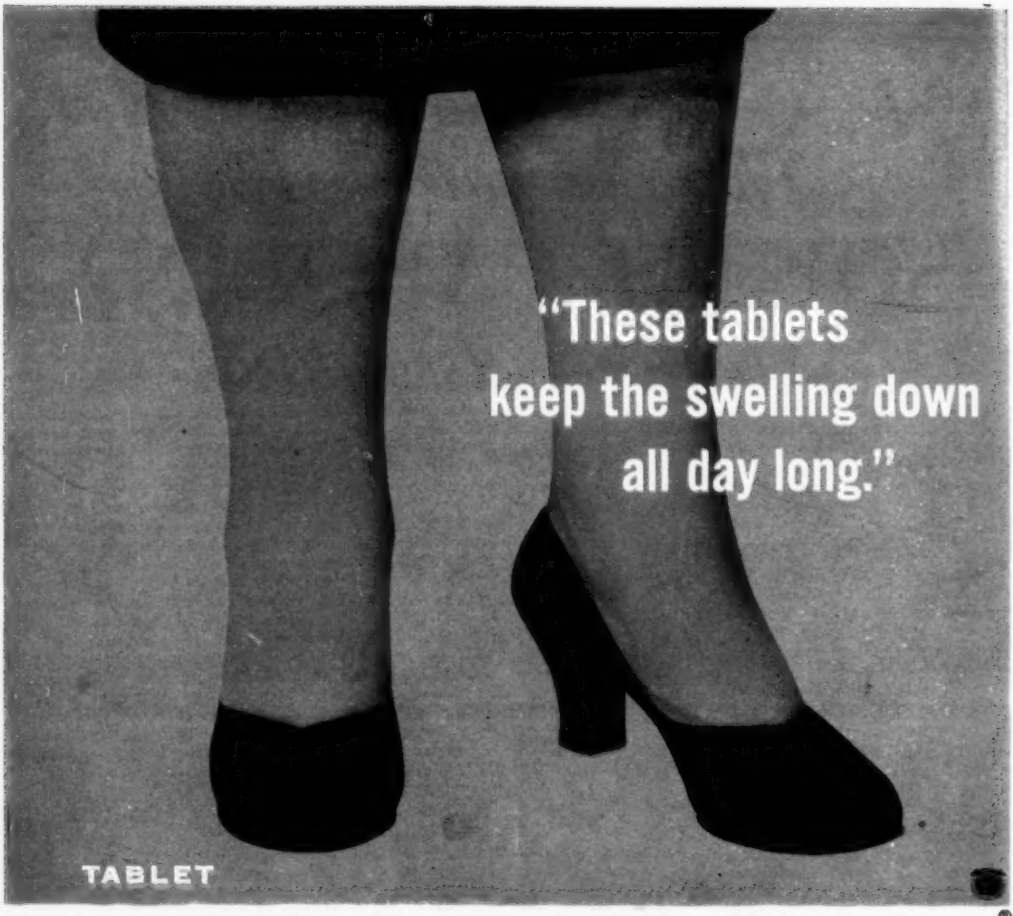

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Treatment of Neuroses in General Practice

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Philadelphia, Pennsylvania

Scientific methods of treatment for neuroses have developed steadily since the first world war and have received a fresh stimulus since the second world war, particularly in the direction of more rapid techniques for more rapid rehabilitation.

Through this period there has been a gradual tendency to set aside older, though still usable, treatment systems and rely almost wholly on analytic procedures for the care of these patients.

While it is generally agreed that a formal psychoanalysis is probably the most satisfactory method of reaching for and correcting the fundamental causes of neuroses, nevertheless, the very formality, rigidity and time factor of this procedure renders it unavailable to most of those requiring it.

It has become necessary, therefore, to develop more practical methods of treatment which can be made available to the average patient wherever he is.

For these reasons, although most psychiatrists tend to follow certain fundamental principles in their understanding and interpretation of neurotic symptoms and emotional manifestations, there is a decided difference in the methods of approach, in the management of patients and in psychotherapeutic procedures. An enormous number of psychoneurotic patients have to depend entirely upon the care of physicians in general practice who, by and large, have been carrying these patients along in an increasingly more satisfactory manner.

Psychiatrists seem to cling to the larger cities so that they are not generally available in many of the smaller towns, and are particularly inaccessible to the rural districts in most areas.

The custom is increasing therefore, for the rural general practitioner to send his patient to the nearest city psychiatrist from whom he then properly expects a complete diagnostic survey, an evaluation and explanation of the neurosis, a practical plan for management, and suggestions for psychotherapeutic procedures, sufficiently practical to allow the family doctor to continue adequate care of the patient, with an occasional revisit to the psychiatrist for follow-up and further suggestions.

This would obviously require that the family doctor have a working knowledge of the major psychopathologic entities and the ability to understand and deal with people. Further it is essential that the psychiatrist be thoroughly practical in the recognition of the difficulties which arise in the handling of such a patient in a busy general practice where the time factor alone presents an important problem.

In discussing any method of treatment for the handling of nervous patients it may be well to keep in mind that all does not depend alone on psychotherapy, and that psychotherapy is not limited only to the interpretation of psychopathology.

The first recognized psychiatrist, Imhotep, the Egyptian about 4000 B. C., recommended, for those patients who were in distress of mind or soul, that they be taken to quiet watering places to have baths, soothing massage, quiet music and peacefulness around them.

Down through the ages this principle of controlling the environment to lessen stress

for the nervous patient has been followed.

Through the monumental work of Freud and his followers in revealing mental mechanisms and psychopathology, interest more recently has been very largely directed toward an attempt to understand the dynamics, the motivation and the conflict situation of the neuroses.

Therefore, treatment in psychiatry in recent years has been directed toward the uncovering of instinctual urges, to the recognition of specific failures in adaptation, to the unraveling of conflict situations and to helping the patient to understand the meaning of his symptoms, and to tolerate and control his emotional problems.

Briefly a few of the principal motivations which drive all of us forward are (1) an effort to attain mastery over ourselves, (2) to attain social approval, (3) to possess security, and (4) to acquire a satisfying love and all that that implies.

Actually full normalcy means a complete acceptance of all dynamic drives, the possession of adequacy to withstand stress in all spheres, and the ability to function as an asset to one's group.

A failure in any direction means frustration, which, if well controlled, indicates satisfactory adjustment; though if uncontrolled, means maladjustment. To use simple terms, then, maladjustment means unsatisfactory controlled frustration. Thus we are presented immediately with a point of attack for treatment even though we may not have an opportunity to go further in our investigation to determine the origin of the frustration and the reasons they are uncontrolled.

Treatment must include then, adequate training in the control of responses to a frustration which cannot be altered.

Where it is possible we attempt to go behind the curtain of inhibition and defense in an effort to determine the nature of the frustration, and further to define and clarify the conflict situation behind that, and to understand the dynamic forces at play with their specific emotional distortions. Through cautious interpretation of the meaning of symptoms and careful re-education, we may be able to relieve our patients of some of their emotional turmoil and frustration, and to render them more adequate to accept comfortably their own self control.

Our objective is correction of maladjustment and development of personality adequacy. Any outline of psychotherapy therefore involves teaching the patient to understand his situation within himself, the nature of his illness, and his weaknesses. He would have to learn his limitations and make adjustments to them. He would have to learn what dormant abilities he may have and to develop them for an aid in furthering self-confidence. The patient must be taught to develop control of himself. He must be taught to dominate his emotional crises and to react with intelligence, and eventually to develop sagacity in the handling of his personal problems.

We must recognize in many patients with neuroses an etiological predisposition of lower resistance, and a hypersensitiveness to stress in a person who easily develops self-protective avoidance reactions. The maladaptations then are the result of faulty habit reactions and a failure to accept control as a normal experience in handling within oneself sex urges, separations from parents, the hazards of adolescence and responsibility and obligation of adult life; all of which means normal discipline. Patients therefore who are unable to face undue stress are unconsciously seeking escape by some substitute or compromise reaction which we call a psychoneurosis. Such patients are filled with anxiety and are in a state of fear toward their symptoms, their environment and their future, and, by reason of many failures to obtain relief, are apprehensive and doubtful that any help may be given them.

The technique of treatment of a psychoneurotic person requires careful, detailed study of the individual case, and must be undertaken with the spirit of warm, friendly interest and the establishing of the confidence of the patient in the physician. It is well to allow the patient to "talk himself out", to tell his story in his own words, and later to elicit from him a detailed history as to his heredity, his illnesses, his education, career, family life, financial stability, and so forth. Having these facts arranged in chronological order, not only

helps the physician in his estimate of the patient, but establishes further a certainty in the mind of the patient that the physician understands all of his problems and all of the factors in his background. Next a detailed history of the neurosis itself is obtained, in which all of the present symptoms are noted, and an attempt should be made to determine the time of onset of these symptoms as nearly as the patient can trace it. Also there must be obtained an account of the circumstances and the causes of the illness as the patient believes them to exist.

A complete physical and neurological examination with indicated laboratory procedures is most essential, not only to uncover somatic disability and dysfunction, but in furthering the complete perspective of the patient in the mind of the physician, and also in building further confidence in the mind of the patient in his physician. All physical disabilities uncovered must be expertly treated and controlled to give the patient the best possible opportunity to get well.

During the taking of the history and the making of these examinations the physician has been reaching a careful psychiatric evaluation of the patient.

Immediately after the first complete survey of the patient has been made, the physician should have a frank talk with him, explaining directly and in simple terms the significance of all the findings in the case, correlating the various factors, and terminating his discussion by outlining what is to be done in the way of constructive treatment.

In the busy doctor's office a thorough investigation on the first visit certainly is not usually convenient or practical, and it is often necessary to plan specific appointments to complete these examinations before formulating a fixed plan. Where possible such appointments should be carried out within the next two or three days, and brought to a prompt conclusion, for delays are frustrating and destroy confidence.

The doctor's talk to the patient must be positive as well as frank, and his advice and decisions must be on a personal, practical and sensible basis. Obviously such talks must be phrased in the manner suitable to the ability of the patient to understand and accept them. It is always well to emphasize to the patient the doctor's understanding of the genuineness of his complaint and an appreciation of the fact that he is really suffering; always being careful not in any way to belittle him, or make him feel inferior, but to protect his pride so that he will sense as the result of the discussion that something has been added to his personal dignity.

In order to devote the required amount of time to such a patient many general practitioners have found it expedient to assign certain hours each week by appointment for these patients, and to charge them additionally for the time consumed. The members of some county medical societies have drawn up agreements among themselves for the establishment of some uniformity for such a custom.

Since time is always a factor in the handling of a neurosis, it is frequently quite practical to allow patients to do a certain amount of home work, to help them to uncover some of the outstanding factors in their history.

Most patients rather readily accept the suggestion of writing out an autobiographical sketch, particularly if it is made simple and in outline form, and if it follows planned assignments to be discussed by appointment. It seems easiest for most people to recall their histories in chapters based on pre-school, primary and grammar grades, high school, college, career and so forth. To prevent a long bulky essay it may be well to suggest that they just make headline entries of good and bad experiences. It is sometimes surprising to discover the amount of material some patients can recall and bring forward about significant experiences which they had long ago forgotten.

The accomplishment of an autobiographical sketch in regular sequence can be considered part of his treatment program and becomes important to the patient. He is told specifically to assign himself to a half hour a day for this task, such as a half hour immediately before retiring, when he is to sit quietly alone and let ideas slide through his mind and then jot them down.

Such an outline furnishes a guide for full discussions which may bring forward much

material significant to the physician in his effort to help the patient understand himself. Caution should be exercised not to interpret the material too quickly, but to keep a record of certain items for consideration in the all-over evaluation of the problem, and perhaps later use some of this information in an effort to help the patient develop an insight into the beginnings of his neurosis. Gradually, as his confidence increases, he will learn to make many of his own evaluations, and with the guidance of his understanding physician, will come to recognize why it was necessary for him to have neurotic symptoms, what they meant, and to discover that he no longer needs them.

Later when the autobiographical sketch is fairly complete it may be possible to turn the patient's interest back into determining, through the various phases of his life, those things about which he developed hatreds. It may be possible to get him to discuss many of his accumulated hatreds and loves in the past years without becoming too involved.

It is quite important to recognize in certain disclosures made by the patient some deep-seated emotional conflict situations, which the physician himself may not be able to interpret, but which he can note and lay aside as one of the factors to be discussed later with the psychiatrist who is collaborating with him in the handling of the patient.

While an effort is continually being made for the patient to understand his problems and to learn new ways of handling himself, the doctor must be cautious not to cause confusion by moving forward to rapidly in any re-educational program. All patients will require repeated re-assurance, encouragement and an opportunity to express themselves freely as to their emotions, their doubts, their fears without risk of censorship, so that they may gradually discuss matters of serious moment with less and less sense of guilt, anxiety and emotional turmoil.

Frequently it will be noticed by the attending physician that his patient will approach a subject for discussion only to veer cautiously away from it, because the discussion of that particular subject may be too distressing to him emotionally. It may be well to quietly make note of such matters so that at future interviews they may be cautiously presented for further discussion.

Many patients will have a block of natural defensiveness and inhibition which will prevent them from discussing emotional problems which they may be barely able to recognize in themselves, or which may be kept out of conscious mind because of the nature of the threat which they carry.

Many past experiences of considerable significance in the clarifying of a neurosis may thus remain buried.

To relieve such situations it has been found expedient to use sedatives such as amytal and pentothal intravenously, slowly administered, to gently induce a less than full conscious state and yet maintain sufficient wakefulness that an outpouring of previously blocked off emotionally disturbing material may be freely expressed.

If carefully managed a lot of valuable historical material can be obtained in this manner for careful future discussion and explanation.

Frequently it is possible to review the same situation in later sessions under less and less sedation until the patient can begin to discuss these subjects consciously and with less and less emotional impact.

Occasionally reliving, with understanding and confidence, a previously blocked-off threatening experience, that is abreacting it, will be tremendously relieving emotionally and may be the turning point in recovery from the neurosis.

Some patients who manifest resistance to talking out may be aided by using twenty mgm. of methedrine with three and three-quarters grains of amytal, for methedrine activates and speeds up cerebration and renders talkative many who have very little verbal ability.

Caution to avoid over-dosage and excessively prolonged stimulation is of course necessary.

The doctor must understand that there are times when the patient will develop emotional feelings toward his doctor, sometimes for and sometimes against him as an inevitable part of any self-exploration. Under such circum-

stances the doctor must be objective and direct the patient into an understanding of the reason for these feelings. Many patients will gain security by developing some dependency upon the physician for a time which will be necessary to them. As the opportunity arises it will gradually be possible to develop in the patient enough self-assurance that this dependency upon the doctor or anyone else becomes less and less a necessity.

In the handling of a neurosis it is necessary to keep in mind the strengthening of the ego, that is to say, the strengthening of the directing or controlling portion of the personality of the patient, for it is the failure in his ability to be able to direct himself in the presence of conflict situations that permits him to have a neurosis.

The doctor's effort therefore, is not only to understand the patient and to have him understand himself, but to teach him new habits of adjustment which would in turn develop this personality strength. Management of the patient through this training program must be thoroughly realistic. He has to learn to develop a tolerance to fatigue, to stress, to adversity, to depression, to anxiety. Through the doctor's re-assurance and his own re-education he gradually learns to accept many of these manifestations of his illness which will fade away gradually as he gains inner strength. New qualities, new aptitudes must be found to capitalize upon with which to develop greater confidence in himself. He can learn to dominate his emotions rather than allowing them to dominate him. He can learn to be intelligent rather than emotional in his decisions and to devise new ways of meeting problems. In other words, any treatment program would involve the unlearning of bad habits of meeting problems and the learning of good habits of meeting those same problems.

In the treatment of any neurosis the members of the immediate family of the patient must come into consideration and not infrequently will require some education in the direction of tolerance of the patient and his symptoms and an understanding of what the patient and the doctor are trying to accomplish so that full cooperation may be attained.

Throughout a therapeutic program a definite sequence must be adhered to and followed persistently, though with reasonable elasticity. If the doctor does not keep notes, does not follow a sequence for orientation from interview to interview, the patient soon will feel confused and disorganized. A therapeutic program is a teaching schedule and should be arranged to proceed steadily ahead from visit to visit so that the patient, but particularly the doctor, has a plan to guide him throughout treatment.

Most patients should be treated on a work basis, that is to say, at home and on the job, rather than in a sanatorium. The usual patient suffering from a severe neurosis may require a few days in the hospital for a complete study. Those with profound exhaustion and other serious somatic manifestations may require the isolation, rest and security of sanatorium care. Patients who are sufficiently ill to require sanatorium care are so usually because the stress at home and in the office is too great, so that little good will accrue from sanatorium treatment unless complete isolation is insisted upon. To obtain isolation and rest the elimination of visitors and the telephones are essential.

In every case a gradual effort must be made to re-establish the patient in some activity and useful work to maintain specific contact with reality and to aid him to again fit into a social group.

Occasionally a few days under modified narcosis, with hypnotics carefully controlled, is very comfortable to anxious, tense, nervous persons and allows them to get off to a good relaxing start.

Under a routine regime of rest, most patients will readily gain weight. Those who do not and in whom this seems particularly indicated, may be helped considerably by the use of small doses of regular insulin, 15 or 20 units injected intramuscularly, a half hour before each meal. Mild signs of hyperinsulinism may occur, but are usually not very disturbing and are readily alleviated by the use of a lump of sugar or fruit juice. The patient should be supplied with orange or grape juice as a convenient and freely used beverage, off and on all day, and told to carry a few lumps of sugar. Occasionally an eggnog as a regularly

timed diet between meals is very helpful.

A direct effort must be made to build up good muscle tone, at first by means of massage and then gradually increasing exercises. Rest periods after massage, after exercise and after lunch should be insisted upon, preferably in the open air.

Insomnia may be controlled by the use of sedatives, but these tend to be depressing if long continued. It is well to determine the amount of sedation needed and to give it in divided doses such as 7 p. m., 9 p. m. and 11 p. m. The dosage should be enough to insure a full night's rest, and thus avoid the need for medication during waking hours in the early morning period, since patients readily develop the habit of waking for medication at that time and can as easily acquire the habit of sleeping through the night.

Occupational therapeutic measures which are suitable to the specific patient are extremely helpful in re-establishing the ability for concentration and interest, and in resting highly tense nervous patients through the use of their hands, while aiding them to mix with a group on a common level of activity.

All decisions as to rate of progress, amount of work, type and degree of exercise and all other activities are the responsibility of the physician who must have complete disciplinary control at all times. It is extremely important that nurses in charge of such cases understand distinctly the relationship of the authority of the physician to the patient, and also that the nurse be capable of maintaining a friendly control of the situation surrounding the patient.

The gradual development of tolerance to fatigue requires accuracy and caution, so that the advances made are regular and not dependent upon the desire of the patient, and the confidence of the patient in his progress must not be upset by too much enthusiasm in forcing him beyond his actual ability to withstand fatigue.

Medication in the handling of neuroses is largely symptomatic, although it is popular to give vitamins in massive doses, and tonic prescriptions of various kinds are sometimes helpful, such as nux vomica in exhausted cases. For those who are particularly anxious and tense, and show many autonomic nervous system signs, a prescription containing gynergen, belladonna and phenobarbital has proved very comforting.

When simple depression is a prominent symptom in the course of a neurosis, it will often be found quite helpful to administer dextro-amphetamine sulphate either as a tablet or as a "spansule." The dosage may have to be reduced or increased according to the reaction upon the patient. This therapeutic adjuvant has the ability to lessen the depth of a depression and in overdoses may even produce a mild euphoria and pronounced insomnia. Therefore, dexedrine should always be administered during the morning hours. In tense, anxious states, dexedrine not infrequently adds to the discomfort of the patient, causing restlessness and agitation instead of elation and must therefore be used with judgment.

The danger of dependency upon medication of any form is present in the apprehensive neurotic patient who is looking for supports to lean upon, so that frequent changes in prescriptions would seem advisable. Many patients who have long suffered from neuroses have been taking one or another form of bromide or barbiturates to the degree of addiction and are found to be suffering from low-grade chronic bromide or barbiturate poisoning.

Infrequently there will occur patients with neuroses who have an accompanying deep reactive depression of such severity that all usual methods of treatment are impractical and the depression itself must be controlled.

Electro-sleep treatments are helpful at such times though always administered under deep sedation to lessen the patients awareness to the procedure and to minimize the convulsive reaction. Four or six such treatments are usually enough to control the situation and permit usual psychotherapeutic procedures to be continued.

Rarely one finds a patient with a chronic intractable deep-seated neurosis, usually obsessive compulsive in type, who is completely invalided and in whom all usual methods, even electro-sleep, have failed to relieve to any degree. Such a patient may be entitled to

the relief occasionally obtained through thermal lobotomy. This procedure is simple and safe in expert hands and has the great advantage of accurate surgical control so that dosage can be measured and repeated easily as required. In some seemingly hopeless cases considerable relief from tension, anxiety and depression has been attained and rehabilitation made possible by this method. These are exceptionally rare cases and must be carefully selected and these procedures considered with great caution.

For the treatment of the psychoneuroses there have been elaborated many psychotherapeutic procedures some of which tend to deviate at tangents involving complicated psychological concepts and overlooking the patient as a whole. It is well to keep in mind that every part of the program planned for the treatment of the patient has some specific psychotherapeutic value as it contributes to the confidence, the understanding and the recoverability of that patient. Every contact with the physician, every change in routine, every alteration in medication may be considered also as having a psychological significance and therefore has psychotherapeutic value.

Whatever form of psychotherapy is attempted will be definitely colored by the personality of the physician, his understanding of the patient, and his ability to develop complete confidence of the patient in him as a physician, and to counsel with and to direct the recovery of this particular patient. The personality and training of the physician frequently determines the method in which he is most successful. One physician will be dominating and aggressive, while another will be re-assuring and persuasive, but in any case positiveness is most essential that the physician may direct the patient's tendencies, and teach him to recognize the struggle he is making between his desires and his wish to attain an average existence in a cultural environment, until he gradually begins to recognize in himself an individual personality in which he can develop pride, and so reach toward a better level of adequacy.

The principles involved in the psychotherapeutic procedure may be summarized therefore as follows: first, the development of complete confidence and respect by the patient in his physician; second, an opportunity to talk out his problems in detail; third, the patient must learn to face his avoidance reactions by careful explanation of them and the assimilation of advice and suggestions of the physician; fourth, gradually develop insight into his difficulties; he must learn to understand the meaning of his symptoms; fifth, he must develop new mental habits for meeting his problems, which will involve adjustment to his social environment, a recognition of all of his good qualities, a recognition and ability to utilize those qualities which he possesses which will give him power over himself and his situation, and a learning to accept again responsibilities on an active level.

In any discussion of treatment of a neurosis, the question of prevention must be considered and here the importance of the methods of mental hygiene must be emphasized, particularly as applied to early childhood and adolescence. The interest in this subject in parent-teacher groups and in various organizations throughout the country is most encouraging and it is definitely helping to prevent psychoneuroses in adults. A formal psychoanalysis should never be attempted except by an expert in this field, and then only on a very limited group of specially selected patients. A careful follow-up program for every patient with a psychoneurosis is necessary for at least a year or two, for he will be facing problems, both old and new, which he seems almost able to combat, but cannot quite do so. He needs the additional assistance of his physician to carry him along until his tendency to avoid problems is completely overcome and he is again meeting and handling all of his difficulties adequately, with complete self-assurance and mastery over his situation.

The management of neuroses therefore becomes the duty of every physician, particularly of the physician in general practice, who has the greatest opportunity to help the patient in the incipiency of his neurosis.

It may be well to keep in mind that any ill patient from whatever cause, is facing the result of fear of his illness, whether conscious or not, as well as the necessity for adjustment to

a new and strange situation, with the threat of not only physical and mental but also economic insecurity. Any physician, wherever he may be practicing, is definitely more helpful to his patient when he demonstrates some understanding of the psychological factors involved during a physical illness.

Every thoughtful physician can readily acquire the art of seeing through the eyes of his patient the specter of disability, even if temporary, and the emotional consequences reacting through the patient and members of his family. Some of these, often barely noticed factors, may influence the nature and duration of the illness very materially and can be tremendously relieved by a physician who takes time to understand.

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The Diagnosis and Treatment of Meniere's Disease

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It is unfortunate that the Diagnosis "Meniere's Disease" is made in many cases of dizziness without proper regard to the triad described by Meniere. The diagnosis should be retained for the condition characterized by nerve deafness, tinnitus and vertigo; the pathological change in which has been shown to be a hydrops of the endolymphatic labyrinth.

Meniere's Disease (endolymphatic hydrops) is primarily a cochlear disease. A careful history will reveal that the disturbance of hearing is present usually a long time before the disabling symptom of vertigo appears. The patient usually presents himself complaining of vertiginous attacks with an accompanying tinnitus; the history of deafness has to be elicited.

VERTIGO

This is a true aural vertigo. The patient states that the vertigo may come on suddenly at any time. Frequently it will occur when he is in bed. There is a sensation of objects moving in a rotary fashion or sometimes he complains that he himself seems to be spinning. The vertigo is usually accompanied by nausea and vomiting and is incapacitating. It may last for a few minutes or for several days. The attacks may occur fairly regularly at two weekly or monthly intervals or occur frequently and at irregular intervals. There may be long periods of freedom from attack.

TINNITUS

The tinnitus is usually of two kinds (a) a roaring sound likened by some to the sound heard on holding a sea shell to the ear. It may be described as "the sound of surf on the seashore" or "of a wind in the forest" and (b), an intermittent and much less bothersome high pitched ringing. The constant roaring tinnitus is the more troublesome of the two. In many instances the tinnitus either disappears just preceding a vertiginous attack or may become very much louder temporarily and be followed by the vertiginous attack.

DEAFNESS

The patient notices a loss of hearing in the affected ear. He usually can state that although he hears sounds, the sounds are distorted and they sound different in the two ears (diplacusis). Although speech can be heard it frequently cannot be understood. The hearing

varies considerably and patients will state that at times they hear "perfectly" while at other times there is a "sense of pressure or fullness" in the ear and the hearing ability is impaired. Those patients who are musical complain bitterly of the difference in pitch appreciated by the two ears. Many patients state that loud sounds hurt the affected ear.

EXAMINATION

Usually the examination of the ear, nose and throat is unrevealing except for the functional tests of the ear.

AUDIOMETRY

Fork tests as a rule give characteristic findings of nerve deafness. The Rinne test is positive. The Weber is referred to the better ear. The Schwabach is diminished. Comparison of the sounds made by a tuning fork held close to each ear alternately reveals that the same fork may sound higher or lower in the affected ear than in the normal one. The sound, too, is not clear but is described as "fuzzy". Diplacusis may be present only in the low tones or only in the high, or maybe confined to only one frequency but it is nearly always present. This diplacusis can be measured. The pure tone audiogram reveals a threshold loss of hearing more marked in the low tones in the earlier stages later becoming a flat loss throughout the scale and still later showing a greater loss for the high frequencies. The bone and air thresholds are equal. Loudness balance tests reveal recruitment or hyper-recruitment. Speech audiometry is helpful in the diagnosis and characteristically shows a proportionally greater loss for discrimination than at threshold. We have found in our cases that whereas the loss of threshold for speech is perhaps only 40 decibels the discrimination score is frequently less than 30%. On the contrary with lesions other than end organ lesions the threshold loss may be as great as 60-70 decibels but the discrimination score may be 50-60%. We feel this is an important point in the differential diagnosis between Meniere's Disease and lesions in the cerebellopontine angle. It confirms the observations of Eby and Williams and of Hallpike.

Caloric tests are not diagnostic in Meniere's Disease. In the early stages one may find equal responses in the affected and unaffected ear. Later as a rule the affected ear becomes hypoactive and one may find a directional preponderance to the unaffected side. We use the Cawthorne Hallpike mthod of testing, douching with water 7° centigrade above and below body temperature for 40 seconds and timing the duration of nystagmus. In long standing cases one may get no response to stimulation of the affected ear even with maximum stimulation with ice water.

TREATMENT—MEDICAL

Although the etiology of Meniere's Disease is not known, there is accumulating clinical evidence which points to the possibility of a vasomotor change leading to spasm of the internal auditory artery. Such vasomotor change may be the result of an allergic state, for example, a true hypersensitivity to foods or inhalants. Endocrine imbalances, or psychogenic stimuli may have an effect. It is of importance to investigate all possibilities and eliminate the possible causative factors. However, such investigation is difficult and frequently time consuming and treatment should be instituted early. If the theory of a vasospastic state is correct, it is important to relieve this spasm and vasodilators have been recommended. Our routine has been the use of Roniacol or nicotinic acid 50 mg. together with thiamine chloride 10 mg. and ascorbic acid 250 mg. three times a day with meals. In addition Banthine, 50 mg. or Probanthine, 15 mg. is given every six hours. In some cases atrophine 1/50 Gr. t. i. d. by mouth has proved beneficial. In many cases this has prevented the dizzy spells, although in others even under such therapy the patients have had attacks.

Derlacki and Shambaugh emphasize the use of histamine in small doses. They recommend 0.1 cc of a 1 to 100,000,000 dilution as the test dose. If the patient improves as evidenced by the diminution of the tinnitus and a lessening of the vertigo, this dose is given twice a week. If no improvement, then 0.1 cc of 1 to 10,000,000 and subsequently 1 to 1,000,000 or 1 to 100,000 dilutions are used until the appropriate dose is found. When the appropriate dilution is found it is injected either once a week or twice a week. We have not had experience with this regime ourselves so cannot comment further about it. We have on many

occasions used intravenous histamine in an attempt to treat an acute attack but so far with no success. Fowler, sometime ago, suggested the use of large doses of streptomycin to destroy the vestibular function. The recovery from doses as large as 4 grams a day for three weeks is slow and the patient is ataxic and very uncomfortable for quite sometime. There is also, in this therapy, danger of further injury to cochlear function. Recently Schuknecht has employed streptomycin in doses of 2-3 grams a day but he has done caloric tests daily and hearing tests every other day and finds that if the drug is given properly the diseased labyrinth loses its activity without damage to the normal labyrinth. He further states that the hearing in his cases has been improved both in regard to threshold and discrimination. The dose of streptomycin must be very carefully regulated.

In a few cases we have used large doses of vitamin B_{12} with apparent success. The dose is 1,000 micrograms intramuscularly daily for thirty days and thereafter as a maintenance dose at intervals to be determined. Although the cases that have benefited from this treatment are few, it perhaps warrants further trial. As an example a case report follows:

A 27 year old, white male was first seen in October 1951, sent in by his own otologist, complaining of ringing in his ears which started while he was in the service from 1943 to 1946. His first dizzy spell was in 1949. The dizzy spells had been more frequent in the past year. They were very severe and lasted four or five hours. His last attack before being examined by me was two months previously. He stated that the ringing in his ears became louder for about two hours before the dizzy spell started.

Examination of the ear, nose and throat was essentially negative. His tests showed a nerve deafness in the right ear, more marked in the low tones; a normal left ear. He had hyper-recruitment, a definite diplacusis at 4,000 cycles and his speech tests revealed a threshold loss in the right ear of 39 decibels with 44 per cent discrimination. The left ear had normal threshold with 96 per cent discrimination. He was considered for surgery because his work necessitated climbing on grain elevators and he was afraid that he might have a dizzy spell at a time when he was on a height and might lose his balance and hurt himself. However, he was put on medical therapy in order to allow him to postpone surgery until after the new year. During this time he had vitamin B_{12} injections daily for thirty days and in February 1952 he was retested and his threshold in the affected ear was now found to be 16 decibels with 94 per cent discrimination. He continued with his B_{12} and has been tested on March 1952, October, November 1952, January and July 1953 and the last test was done on October 1953 at which time the hearing was normal in the right ear with 96 per cent discrimination. During this time he has continued with injections of vitamin B_{12} at intervals of a week to ten days. He states that he can always tell when he needs an injection because the tinnitus increases. During the period he was on B_{12} we gave him some placebo to inject; this happened to be phenolsulfonphthalein. The ampule had the same appearance, color, and so on as the B_{12}. He returned after a few injections complaining that the material was not the same as he had before because he found that it did not stop his tinnitus and that he had had a dizzy spell. He was put back on B_{12} and since then has had no further trouble.

Normal remissions in this disease make it difficult to evaluate therapy and one must be guarded in ascribing to therapy what may be the result of a normal fluctuation in the disease.

SURGICAL

When the patient has not been helped with medical management and has become incapacitated or handicapped by his disabling vertigo, destruction of the labyrinth will give complete relief to the symptoms, provided, of course, that the disease is unilateral. It is emphasized that labyrinthotomy is reserved for cases in which the disease is unilateral.

The operation of labyrinthotomy, which was first described by Day in this country, is a simple procedure performed either through an endaural or a postauricular approach as the surgeon desires. Enough mastoid cells are exenterated to allow for a direct approach to the horizontal semicircular canal and, particularly,

to its anterior end. I find it best to remove the incus and the head of the malleus to have an easier access to the vestibule. A large opening is made in the vestibule. The endolymphatic labyrinth is avulsed and after the area is carefully dried a coagulating current is applied to the vestibule in order to destroy both utricle and saccule completely.

Results from labyrinthotomy have been universally good if an adequate destruction has been done. If, however, the utricle and saccule are not completely destroyed, the patient, although he may have no true vertiginous attacks, may be unsteady and have difficulty on forward motion. A case: T. B. age 49, had had symptoms of Meniere's disease for many years. Caloric tests showed a complete absence of response from caloric stimulation in both labyrinths. He was constantly unsteady and complained that when he met people on the street and turned quickly to look at them he was apt to stagger and was frequently accused of being inebriated. A labyrinthotomy was performed and coagulation of the endolymphatic labyrinth accomplished. After the wound was healed he still complained of a sensation of unsteadiness, particularly, on forward motion. He stated that as he walked down the street the horizon would jump up and down constantly and it was a very disabling condition. Furthermore, on quick turning of the head when he was walking he would definitely stagger to his left side. A revision of the operation was performed and very careful destruction of the whole vestibular labyrinth was accomplished since when he has had no further disability.

There should be no danger from the procedure of labyrinthotomy. There have been reports of facial injury following coagulation of the labyrinth. This is probably due either to improper placement of the coagulating electrode so that it approximates the underside of the facial nerve or possibly might be caused from heat in the area if the area is not satisfactorily dried before the current is applied, in effect boiling the under surface of the nerve. In any event if the patient does by misfortune wake up from the anesthesia with a facial paralysis following the operation no time should be lost before the nerve is completely decompressed.

SUMMARY

1. The term Meniere's Disease should be confined to those cases exhibiting the classical triad of tinnitus, vertigo and nerve deafness, the result of endolymphatic hydrops.
2. The functional tests of hearing are important in these cases and exhibit 1) a nerve loss usually flat throughout the scale of pure tone audiometry, 2) recruitment or hyper-recruitment, 3) diplacusis and 4) a comparatively great discrimination loss for the threshold loss of hearing for speech. Caloric tests may not be informative in Meniere's Disease but in long standing cases usually show a hypoactive labyrinth on the affected side.
3. Medical therapy with vasodilators, with histamine, or with B_{12} may give some relief to the patient. The results of therapy should be estimated in the light of the known periods of remission in this disease.
4. The surgical ablation of the labyrinth will give complete relief in cases of unilateral hydrops provided a complete destruction of the vestibular labyrinth is accomplished. It is important that the utricle and saccule as well as the semicircular canals are destroyed.

Tinea Capitis

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Tinea capitis, commonly called "ringworm of the scalp", is a fungus infection principally involving the hair. It most frequently occurs in children before the age of puberty. The fungi causing this disease are *dermatophytes* of the two genera *Microsporum* and *Trichophyton*. The fungus invades the stratum corneum, the top layer of the epidermis. Later it enters the hair follicle, and finally, the hair shaft itself. These fungi infect only the epidermis and the epidermal appendages. They never invade the body to produce systemic disease.

SYMPTOMS:

The cardinal symptoms of tinea of the scalp are partial loss of hair in patches, breaking off of infected hairs, and varying degrees of inflammation. The inflammation may be as mild as simple scaling. It may be as severe as a painful, elevated, boggy, erythematous localized mass which is called a kerion. The kerion usually results in atrophy and scarring. The various types of *Microspora* and *Trichophyta* present different individual clinical pictures. These various clinical pictures will be described briefly:

1—*Microsporum audouini*: This fungus is transmitted by humans and is responsible for the epidemic forms of tinea capitis in children. It is almost never found in adults. It is one of the most common causes of tinea capitis in this country. This fungus is the cause of the classic picture of "gray patch" type lesions which seldom show anything but the mildest type of inflammatory reaction on the scalp.

2—*Microsporum canis*: This is the second type of ringworm most commonly found only in children. With *Microsporum audouini* it accounts for 90% of all tinea capitis in children. It is transmitted primarily from domestic animals such as dogs and cats, but occasionally may be transmitted from one child to another. It usually produces a greater degree of inflammatory response with resulting alopecia than is found in the simple "gray patch" type of tinea from *Microsporum audouini*. This form frequently involves the glabrous skin producing the typical tinea corporis, or ringworm of the body.

3—*Microsporum gypseum* or *Trichophyton mentagrophytes*: The primary lesions in these infections are immediately acute and severe. The tissue reaction involves the production of a kerion which is elevated, painful, boggy, erythematous, and studded with pustules. It leaves permanent scarring. These infections are not confined to children.

4—*Trichophyton tonsurans*: A fourth clinical picture is the so-called "black dot" ringworm. This occurs in adults as often as in children. Until a few years ago it was considered unusually rare, but there is an alarming increase in its incidence over the southern part of the United States, and many predict an epidemic.[1,2] How it is transmitted is not definitely known, but it is thought to be via animals and humans. The fungus invades the hair in such a manner that the hairs break off at the surface of the scalp and dark stumps in the hair follicles give the typical "black dot" appearance. It may appear to be simple dandruff and so go for years without treatment, thereby resulting in permanent scarring and alopecia.

INCIDENCE:

Tinea capitis has a world wide distribution. It was formerly considered more common in Europe, but in the last fifteen years has been very common in North America. Epidemics of *Microsporum audouini* infection have involved thousands of children over the United States and Canada. In Charleston, South Carolina, a series of one hundred cases proven by culture shows the infections to be distributed as follows:[3]

Microsporum audouini	50%
Microsporum canis	39%
Microsporum gypseum	5%
Trichophyton tonsurans	5%
Trichophyton mentagrophytes	1%
	100%

DIAGNOSIS:

In a child with scaling lesions in the scalp, accompanied by hair loss, tinea capitis should always be considered first. The three procedures for diagnosis include: (1) The Wood's light examination. This light is a filtered ultraviolet light which causes hairs infected with *Microsporum audouini* and *Microsporum canis* to fluoresce a greenish color. This allows not only for quick diagnosis, but for the location of all infected areas; (2) The direct microscopic examination of the hair in a 10% KOH preparation; (3) Culture of the organism on Sabouraud's medium.

Identification of the type infection is important in determining the prognosis for the individual patient. It is also important for the community's welfare because of a possible epidemic due to *Microsporum audouini*.

TREATMENT:

At the present time there is no rapid or simple treatment for tinea capitis which is adequate. This is true because of the mechanical impossibility of getting any drug into the infected hair and hair follicle. Successful treatment is difficult and prolonged even with diligent application of the best principles of therapy.

These principles are: (1) The infected hairs should be clipped, not shaved. (2) Manual epilation of all infected hairs must be done. This is best done with a pair of regular eyebrow tweezers, taking care that the hair is pulled out and not broken off. This may sound like a painful procedure; however, since the hairs are loose in the follicle, they come out easily and epilation does not hurt. It must be emphasized that this is a tedious process and involves time and patience. Each hair removed is a possible source of infection, therefore should be placed in a piece of cotton or tissue and destroyed. The tweezers also will carry the infection and should be sterilized. Time taken to demonstrate the technique of manual epilation to the parent is well invested. (3) Daily thorough shampoo should be done. (4) Diligent local application should follow. Many forms of local drugs have been tried. No single drug is ideal, but the ones most generally successful are combinations of fatty acids and salicylanilide.[4, 5] Asterol Dihydrochloride is also thought by many workers to be worth while, especially in *Microsporum audouini* infection.[6]

A typical adequate routine would be as follows:

Morning—Shampoo followed by
fatty acid solution or Asterol tincture.

Night—Manual epilation.
Ointment—Salicylanilide or fatty acid or Asterol.

This program usually takes two to four months to effect a cure, depending on the diligence of the treatment, especially manual epilation. If results are poor after three to four months of therapy, then x-ray epilation should be considered, especially if the infection is a widespread non-inflammatory type, or if the parents and child are uncooperative. X-ray epilation should be done only by a qualified expert and is a tedious and difficult procedure. Even with x-ray epilation, the above outlined procedure should still be followed until the patient is cured. During the course of treatment, the patient should be checked at least every two weeks. If an acute secondary infection develops, a systemic bactericidal agent can be given.

Cure should be determined by lack of fluorescence under the Wood's light, supported by negative cultures on two repeated occasions at least one or two weeks apart. A negative Wood's light examination in itself is not an adequate criterion for cure because the fluorescence of the hair may be destroyed by some of the local chemotherapeutic agents before the fungus is eradicated. In general, the animal forms with severe kerion formation heal more rapidly and may involute because of spontaneous epilation. Those with little inflammatory reaction heal very slowly and require prolonged treatment. These do not tend to cure spontaneously. However, *Microsporum audouini* and *Microsporum canis* will tend to spontaneous cure at puberty because of the increased fatty acid content of the adult type scalp.

PREVENTION:

Since the majority of the cases of tinea capitis are contagious, prevention of its spread is very important. The simplest way to prevent

spread is for the infected person to wear constantly a washable cap or hat. Combs, brushes, and hats used by the infected person should be isolated and sterilized. He should sleep alone and linens should be isolated. He should not go to a public barber. If he does, the barber should be told of the infection and asked not to use clippers as they cannot be satisfactorily sterilized. All family pets should be examined if an animal type infection is found. If there is spread of tinea capitis in a community or a family group, all upholstery should be checked with the Wood's light. Infected hairs will stay in upholstered chairs, automobile seats, and theater seats where the child's head rests. Many believe children with tinea capitis should not attend school. However, this seems to be an impractical approach to the problem as the infection is of such long duration. A child of school age should be able to cooperate and follow procedures to prevent spread.

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Pathological Conference, Medical College of South Carolina

Dr. Vince Moseley: Mr. Underwood, will you present the protocol on today's conference.

Mr. J. A. Underwood: Present Illness: 24 year old white female admitted to Roper Hospital February 13, 1952, having been in coma for 15 hours after its sudden onset. At the age of 3 years she developed right foot drop which improved markedly after transplantation of Achilles tendon. Slow progressive weakness in right gastrocnemius and quadriceps. Later the left leg became involved, producing a scissors gait at the age of 11 or 12. Progressive loss of use and atrophy of lower extremities followed, with little control over motion. The right upper extremity subsequently became spastic and later moderate involvement of the left arm was noted. Right facial weakness and dysarthria developed just before admission. There were no headaches or visual disturbances. Because of dyspnea, auricular fibrillation, and edema 3 years ago, she was given crystodigin with excellent results. One month prior to admission, generalized abdominal pain, nausea, vomiting, and lethargy developed and lasted for 24 hours. Right strabismus of left eye and slight left exophthalmos appeared, but pupils were equal. Anorexia, loss of coordination in motion of hands and swallowing followed. At about 3:30 a. m., on the morning of admission, the patient began groaning with muscle pain. Lethargy and stupor became prominent. Cheyne-Stokes breathing, auricular fibrillation, and incontinence developed. Both eyes deviated to the right and there were tonic contractions of right facial muscles and the right upper and lower extremities. Following sedation all muscles became flaccid.

Past History: Family History: Father died at 31 of lobar pneumonia. Mother and 6 siblings are alive and well. Had usual childhood diseases. Recent weight loss of 40 pounds. No familial diabetes, tuberculosis.

Physical Examination: T. 99, P. 88, R. 28, BP 104/58. Moderately well developed, slender, white female, comatose, with Cheyne-Stokes breathing. Skin: Color ashen. MM pale. Eyes: Right pupil appeared larger, eyes roving continuously. Lungs: Cheyne-Stokes respiration with 1-20 seconds apnea and marked hyperpnea. CV: Heart sounds of good quality with grossly irregular and rapid rhythm. Musculo-skeletal: Talipes left foot. Limbs flaccid. Neurological: Evaluation of cranial and spinal nerves difficult. Complete areflexia and flaccid extremities.

Laboratory Data: Feb. 14. RBC 5.19 million; WBC 22,700; Hgb. 15 grams; Monos 1; Lymphs 11; PMN 88. Urinalysis: Color—Cloudy yellow; reaction-acid; sp. gr. — 1.026; alb. — ++; sugar — ++++; acetone — +++; pus cells — 4-5/HPF. RBC: 2-3/HPF; epith. cells — +++; casts — 0. BUN: 25 mgm. per 100 c.c. Blood sugar: in A.M., 364 mgm.; per 100 c.c. at 4:00 P.M., 276 mgm. CO_2 combining power: 25 vol. VPC: 40 mm. Spinal fluid: cell count — 1; 100% lymphocytes and no RBC. Wass — QNS. Kline negative. Collodial gold negative. Total proteins 52 mgm. Blood culture — pseudomonas aeruginosa.

Feb. 15. Serum sodium 376 mgm. Serum potassium 16.4 mgm. Blood sugar, early A.M., 272 mgm. 2:00 p.m. 58 mgm.

Feb. 16. BUN 54 mgm.; blood sugar 182 mgm. CO_2 combining power 61 vol.

Hospital Course: Feb. 13. Caffeine and sodium benzoate, penicillin, crystodigin and I.V. fluids given.

Feb. 14. At 4:00 a.m. intern called to see patient. Marked hyperpnea and very short periods ot apnea persisted. Color poor but no cyanosis noted. Extremities spastic during periods of hyperpnea, but becoming flaccid with return of more normal respiration. Heart rate still very rapid and markedly irregular. Blood pressure hovered between 60-90 systolic throughout entire course. T. 103; P.120; R. 34 at 4:00 a.m. 250 units of regular insulin and I.V. fluids given. In afternoon Foley catheter inserted and 500 cc. urine obtained. Urinary output decreased. Character described as dark in color. Feb. 15. 2:00 a.m., only trace of sugar and no acetone in urine sample collected. Continuous O_2 by nasal catheter. Unable to detect pulse. Started developing another rhythm, shown by ECG to be probably complete heart block with several foci of ventricular ectopic beats, later trigeminy, and after rectal pronestyl hydrochloride, a reversion to probably auricular flutter with heart rate 160 per minute. Pronestyl discontinued. Given quinidine gluconate with reduction of heart rate to 150 per minute in 1 hour. Despite intensive therapy, progressive downhill course. She ceased breathing and had a heart rate of 72 per minute which was described as "regular". Very shortly the heart stopped and the patient was pronounced dead at 9:20 p.m. on Feb. 16.

Discussion: Dr. Vince Moseley conducting.

Dr. Moseley: Mr. Barr, this is an intriguing and somewhat complicated case for discussion today. Discuss for us the neurologic states up to the time of admission, giving us the diseases you considered up to this stage.

Mr. W. M. Barr: The most impressive thing is the foot drop which improved by transplantation of the Achilles tendon. Things which frequently cause foot drop are fibrosis of the muscle, upper motor neuron lesions, and position foot drop.

Dr. Moseley: This symptom developed at 3 years of age. Is there any significance to that?

Mr. Barr: It would cause one to think of a congenital lesion, or a chronic progressive disease of muscles, or some other chronic disease such as ataxia or something of that sort. In addition, a lower nerve lesion, for example spina bifida, nerve compression or a meningitis might be considered.

Dr. Moseley: What about an infectious neuritis?

Mr. Barr. Poliomyelitis must be considered. The chronic course would be against poliomyelitis and also the progressiveness of the lesions. Also the observation of a scissors gait at 11 or 12 years is against poliomyelitis.

Dr. Moseley: What would be the significance of the scissor gait?

Mr. Barr: It would indicate some condition leading to an adductor muscle spasm.

Dr. Moseley: The patient is said to have had a bilateral Babinski. Do you think it was present at that time?

Mr. Barr: Yes, I think it could easily have been and it cannot be ruled out. The loss of control and emotional disturbances would point to an upper neuron lesion. This would tend to indicate an ataxia or athethoid characteristic.

Dr. Moseley: What two types of neurologic disease would give us a loss of proprioception?

Mr. Barr: Either a cerebellar lesion or a dorsal column injury.

Dr. Moseley: What about the dysarthria? Does this help?

Mr. Barr: Some cranial nerve is involved, probably the 9th or 12th. The 5th has motor fibers, but does not go into the cord.

Dr. Moseley: What about the cerebellar lesions?

Mr. Barr: Yes, this would cause it.

Dr. Moseley: We have spasticity and ataxia and they are progressive, later involving upper extremities, then facial weakness developed. What diseases must we think of?

Mr. Barr: We must think of a cerebellar lesion and pyramidal disturbance. These are found in such conditions as hereditary ataxia or disease of neurons with a progressive course. A brain tumor may be considered, but it is difficult to focus in time over this long a period and the progressive ascending distribution.

The most common lesion to fit this condition is Friedreich's ataxia. It is said in the books that sporadic cases occur. I think this case would fit the picture of Friedrich's ataxia very well with pyramidal tracts being involved which account for the spasticity. The rest of the symptomatology can be so disturbed as to give any kind of picture. The course of the disease could fit in very well. Talipes equinovarus is one of the first signs observed. There is no scoliosis.

Dr. Moseley: What about the terminal event?

Mr. Barr. We have weight loss and anorexia which looks like diabetes. The upper extremities showing flaccid paralysis with a sudden onset of coma, the albumen, sugar, and acetone are significant. One thinks of diabetes or cardiovascular accident, but she had acetone and I wouldn't think cardiovascular accident would cause that. However, the complete dehydration and starvation could account for it. She was acidotic, with carbon dioxide combining power of the plasma below 20. There is elevation of blood sugar and spinal blood sugar. In addition, there is a positive culture of pseudomonas aeruginosa. This may be a contaminant, but there might be a septicemia or bacteremia. There is no evidence of meningitis. An acute fulminant septicemia might produce this situation without cells in the spinal fluid. When intravenous fluids and 250 units of insulin were given the sugar came down to 58. It does not indicate that the diabetes was controlled and she didn't improve.

Dr. Moseley: What about the cardiovascular system?

Mr. Barr: About three years ago she had auricular fibrillation and was digitalized with some improvement. This was the cause for the consideration of heart disease. Mitral disease or thyrotoxicosis are

possibilities. I think we can eliminate thyrotoxicosis. One must consider coronary artery disease or syphilitic heart disease. The disease I think most likely is rheumatic heart disease.

Dr. Moseley: Of all types of rheumatic heart disease, which one most frequently has fibrillation?

Mr. Barr. Mitral stenosis.

Dr. Moseley: What is the diagnostic sign?

Mr. Barr: Diastolic murmur, and when fibrillation occurs the murmur disappears so you can't rule out mitral stenosis.

Dr. Moseley: Something happened one month before admission—nausea, vomiting, lethargy, etc. She improved and another acute onset suggesting some cerebral lesion with strabismus and pupillary change and roving eyes. Can this be tied together?

Mr. Barr: I would think Friedreich's ataxia is the best bet as the diagnosis. In addition, there is sometime involvement of the heart with auricular fibrillation. There could easily have been repeated emboli to the brain. She could have had emboli to the adrenal or some infectious process in the adrenals.

Dr. Moseley: Does someone else care to comment? Mr. DeVore?

Mr. Robert H. DeVore: My idea was very much the same as Mr. Barr's, but I did consider other things such as disseminated multiple sclerosis. Two-thirds of the cases begin between 20 and 40 and start off with a pyramidal tract lesion such as foot drop. I don't think it is the case here because there are usually visual disturbances by retrobulbar neuritis, and paresthesias. There were no exacerbations and remissions.

Dr. Moseley: What about the bacterial implications?

Mr. DeVore: I don't believe that the pseudomonas aeruginosa is usually involved in a subacute bacterial endocarditis. I would like to discount pseudomonas as a contaminant.

Mr. R. M. Johnson: I think we have made an all too obvious omission; that is the possibility of porphyrinuria. In this condition we would have a similar situation except for the muscular distribution. The acute acquired type can produce this symptom complex, although there would be exacerbations.

Mr. M. G. Evans: I did entertain the idea of a tumor. Certain tumors such as craniopharyngioma. She may have had a medulloblastoma in the cerebellum.

Dr. Moseley: Do any of the staff wish to comment?

Dr. F. E. Kredel: Cerebellar medulloblastoma usually has a more rapid course than this. I tend to interpret this as a cerebellar ataxia or a Friedreich's type of ataxia with the development of diabetes.

Dr. Moseley: A subacute bacterial endocarditis could precipitate a diabetes. Another possibility might be that an acute pancreatitis could develop and explain the diabetic symptoms.

Dr. J. T. Cuttino: (Closing) This is a classic case of Friedreich's ataxia from pathologic anatomic state. I call your attention to these slides. As you see here the spinal cord is smaller than normal. There is extensive atrophy. You see the demyelinization in the portion of the cord usually occupied by the lateral cortico-spinal tract. This is bilateral. It is true that it is more intensive in appearance in the area occupied by the lateral cortico-spinal tract, but it is also to be seen in the ventral portion of the cord in the vicinity of the ventral cortico-spinal tract. In the phosphotungstic acid hematoxylin preparation you see, in addition, an extensive gliosis. In this particular case it is of interest that the dura is markedly thickened. This is not the usual finding in Friedreich's ataxia and I call your attention to one other finding which is also not the usual occurrence. That is: there is a marked sclerosis of the arterioles.

As you know, our knowledge of the etiology of Friedreich's ataxia is extremely confused. That it is a heredito-familial disease has raised the point that it might be congenital. The finding of arteriosclerosis focuses our attention on the possibility of a vascular causation of Friedreich's ataxia. That this might also be congenital is apparent. One reads numerous reports of arteriosclerosis in small children, especially in coronaries. One reads further reports of vascular disturbances in Friedreich's ataxia. For example, there is a report by G. W. Manning[1] of 6 cases of which 4 had T-wave changes indicating coronary disease. Unfortunately, autopsies were not reported. Nades[2] reports additional cases showing coronary disease. So that it seems to me reasonable to believe that there is a vascular causation and this fits in with the appearance of the cord. You may recall that we have had several cases in this same series of Clinico-Pathologic conferences of subacute necrotic myelopathy in which there was a vascular change and in those cases it has been suggested that a vascular disturbance was present.

Can we substantiate this by other findings in this case? This can be very well done in that in the heart there was extensive coronary sclerosis with a diffuse fibrosis and what was formerly called myocarditis. Upon this lesion was superimposed a mural thrombosis. Emboli were liberated and lodged in the spleen, kidney and brain which you can see in these sections. (Demonstrating sections). It is of interest that this mural thrombosis must have been present for some little time in view of the fact that the areas of encephalomalacia in the brain are both new and old and as you note here an organized blood clot in one of the vessels.

In reconstruction then, one recognizes this case as a case of Friedreich's ataxia. The question is presented as to whether or not, at least in this instance, the Friedreich's ataxia was caused by vascular obstruction. This is borne out by the evidence of vascular disturbance in the form of arteriolosclerosis, arteriosclerosis and myocardial degenerations with mural thrombosis and embolization of the kidneys, spleen, and brain. That this patient probably died in a cir-

culatory failure is indicated by the central necrosis in the liver.

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In spite of the scientific triumphs over disease, can it be possible that the physician himself is today in danger of losing the faith and the affection of the people and his time-honored position in society? Dr. Howard Taylor voices this fear when he suggests that "The people are vaguely dissatisfied with the doctor as a person, for they feel that he has become too commercial or too scientific, too busy or too preoccupied to concern himself with their problems."

Who is responsible for this sorry state of affairs? Again within and without the profession, the accusing finger is pointed at the physician's education. This is the culprit who needs to be chastized and reformed. Science, ever more science, they say, is crowding into the educational program and pushing aside the humanities and the social sciences. Lord Horder recently wrote, "The student's pre-medical program is lopsided; almost from the moment a boy or girl decides to be a doctor, the confines of his or her interest tend to become more and more narrow. Medicine, which should have the widest contacts of any profession, almost ceases to be a liberal education, for its cultural outlook dwindles from this moment."

What added acclaim would be Sir William Osler's today were he able to say again what he wrote many years ago, "The wider and freer a man's general education, the better practitioner is he likely to be, particularly among the higher classes to whom the reassurance and sympathy of a cultivated gentleman of the type of Eryximachus may mean much more than pills and potions. In no profession does culture count for so much as in medicine, and no man needs it more than the general practitioner, working among all sorts and conditions of men, many of whom are influenced quite as much by his general ability, which they can appreciate, as by the learning of which they have no measure."

A. E. Severinghaus
J.A.M.A. *155*:417

PITT SOCIETY OF NORTH CAROLINA ASSURES MEDICAL CARE FOR ALL

The Pitt County Medical Society has adopted a program designed to provide the services of a qualified physician to everyone in the county regardless of ability to pay, according to the County Secretary, Dr. E. W. Larkin, Jr.

The program is centered around the Pitt County Memorial Hospital. As a matter of policy, there are no doctor's offices in the hospital. However, a complete "service" staff is on call at all times. A patient coming to the hospital is referred to the doctor covering the service concerned; service appointments are rotated periodically, some monthly, some daily.

Since there are no internes, the hospital staff members voluntarily take their turn in rotation at staying at the hospital from 7 p. m. to 7 a. m. to handle emergencies during the night. The doctor who serves as interne handles everything that he can; if something comes up for which he feels he is not qualified, he calls whoever happens to be covering the service concerned.

The program as outlined above is considered by the society to be successful in providing the needed service.

Public Relations Bulletin—Med. Soc. of State of N. C.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring ---------- 82 Rutledge Ave., Charleston, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) ---------- Charleston, S. C.
Subscription Price ---------- $3.00 a Year

OCTOBER, 1954

Choice of Physician in England

Under current arrangement, members of the British labor unions have had to select physicians in the panel system or pay the private physician out of their own pockets. Now provision is being made by British companies for "fringe benefits" in the form of prepaid medical plans which pay the cost of the private physicians care.

Evidently the workers prefer private doctors of their own selection. After surrendering their free choice, they now seem to repent and want to return to the arrangement which held good before the days of socialized medicine.

From our point of view, this is a healthy relapse.

Southern Medical Association

The annual meeting is to be held in St. Louis, November 8-11, 1954. A large and fruitful meeting is anticipated.

South Carolina is well represented in the organization. Dr. W. Thomas Brockman is a Councilor, Dr. Vince Moseley is Chairman of the Section on Medicine, Dr. R. Wilson Ball is Chairman of the Section in Public Health, Dr. Wm. McCord is Vice Chairman of the Section on Medical Education and Hospital Training.

Various other societies will meet conjointly with the Southern Medical Association.

Cortisone

An editorial in The New England Journal of Medicine* describes the receding tide of enthusiasms over cortisone, and quotes a statement made in April 1953 by Dr. Edgar S. Gordon: " . . . the use of ACTH and cortisone in chronic diseases is becoming less and less justified, probably on the basis of the over-all, long time results, plus a great many complicating factors, including some which are quite dangerous. There are a good many of the best arthritis clinics in the country, for example, which have discarded cortisone therapy completely and have gone back to older methods . . ."

Recently in England further emphasis of discouragement was reported, especially as concerns prolonged use. A carefully controlled comparison of the effects of cortisone and aspirin, used over a period of a year, showed that there was no really appreciable difference in their effects.

An editorial note ends: "It would be ironical if the major practical outcome of the intensive work of the last few years is the discovery that aspirin, given in maximum tolerated doses, is the best and safest treatment for rheumatoid arthritis, the only common disorder for which cortisone is used."

*251: Aug. 26, 1954, 359-360.

Gamma Globulin

There has just appeared a new analysis* of the data on which the claim has been founded that gamma globulin is an effective modifier or preventive of poliomyelitis. Careful consideration of many factors brings conclusions somewhat different from the earlier statements.

A rigid selection of cases of polio showed that many cases diagnosed as polio were due to other viruses or did not show the presence of a virus. Roughly 30% of cases were in this class, a finding which only throws more confusion in the clinician's eyes.

The results of the study are qualified with many vague statements, e.g. (The italics are ours)

"Although the number of cases occurring during the first week is quite small, the direction of observed difference *suggests* that, as in measles and probably hepatitis, if prophylaxis in the late incubation period fails to prevent, it may modify.

"The more accurate data based only on laboratory-confirmed cases lend support to the hypothesis that antibody given during the incubation period has a beneficial effect that can be interpreted either as modification or as prevention, depending on the type of examination and threshold used to determine the existence of muscle weakness. Therefore, unless better evidence has become available, use of gamma globulin after recognized exposure among family contacts or any other contacts of known cases is supported by *suggestive, though admittedly inconclusive, experimental data.* At least, there is no basis for concluding that gamma globulin will not protect under such conditions.

"The results support the effectiveness of use of the agent in suitable circumstances in mass immunization and also suggests its effectiveness in family contacts. *Evidence for both is far from adequate* but tends to confirm the earlier controlled tests.

"There appears to be definite evidence from the controlled studies that gamma globulin protects when given under suitable circumstances. *It is regrettable that these circumstances cannot be more completely described,* but the experiment was designed to answer one basic question: 'Will this amount of antibody prevent poliomyelitis under any conditions if natural exposure?' and not, 'How can gamma globulin be used most effectively in controlling the disease?' *No experiment has been performed yet to answer this second question.*

"These data offer very *suggestive, although not conclusive,* evidence in support of the use of gamma globulin after exposure has occurred."

These are not the positive results which would justify the enthusiasm of the National Foundation for Infantile Paralysis in recommending widespread use of gamma globulin, and in beating the drum for more money for more globulin. The N. F. I. P. has sunk many millions in a great stock of gamma globulin which we do not know exactly how to use, but which must be justified in view of past claims, and must be used to keep the public in a state of constant contribution of blood, sweat, and dimes.

*J.A.M.A. 156, Sept. 4, 1954 21-27.

Founders Day

The Medical College will celebrate Founders Day with a Post-graduate Seminar on November 2, 3, and 4. On the first two days members of the College faculty will present a variety of subjects. On November 4 speakers from outside the state will give four presentations. A program is found elsewhere in this issue of the Journal.

On this same day there will be two special events. One will be the presentation of a portrait of Dr. William Weston at 11 A. M. This portrait is provided by a large number of Dr. Weston's friends and admirers, and was painted by Charles Crowson of Columbia.

In the afternoon, at the time of the Dedication Exercises of the Alumni Memorial House, there will be presented a plaque of Dr. D. Lesesne Smith, who played such a large part in alumni activities. This is given by his family.

Social activities include a buffet supper on Wednesday evening and a luncheon on Thursday. There will be no Founder's Day banquet this year.

The Bricker amendment missed passage by one vote in the Senate last year. It has been introduced again, and warrants the support of all physicians who are concerned with the danger of having various forms of socialized medicine foisted upon them by agreement between nations without individual sanction.

The new Bricker resolution reads: "Section 1. A provision of a treaty or other international agreement which conflicts with this Constitution, or which is not made in pursuance thereof, shall not be the supreme law of the land nor be on any force or effect. Sec. 2. A treaty or other international agreement shall become effective as internal law in the

United States only through legislation valid in the absence of international agreement."

The A.M.A. favors the Bricker amendment as a safeguard against the imposition of domestic law, (including laws affecting medical practice), through treaties.

In our AMA Washington Letter, we note that matters are progressing on "the administration's health program for constructing chronically ill hospitals, nursing homes—". Seems like a poor idea to build that kind of a structure. Too many of our hospital buildings are already chronically ill.

The same letter says that poliomyelitis cases are 7% behind the total for this time last year, yet the National Foundation for Infantile Paralysis gives as one of the reasons for a second March of Dimes the fact that there is a great increase in its case load. Maybe it's time for a mild retreat.

SPECIAL OFFER!
NEW COOK BOOK FOR
LOW SODIUM PATIENTS.
Adv. in J.A.M.A.

We are willing to admit that there are plenty of low patients, but this sodium patient is a rather strange one. Maybe he is a remote descendent of one of those patients from Sodium and Gommorrah.

The Journal of the South Carolina Medical Association

Forty Years Ago

OCTOBER 1914

Dr. R. M. Pollitzer's paper on "Caloric Feeding in Infancy" appeared. Dr. J. R. Young discussed papers read before the Anderson Society. The budget of the Mdical College was $29,500.

STATE BOARD OF HEALTH

Excerpts from Minutes

The Executive Committee of the State Board of Health held a regular meeting on Wednesday, July 21, 1954.

The report of the State Health Officer was read by Dr. Peeples.

It was moved by Dr. Boone, seconded by Dr. Barron, that the State Health Officer be given authority to exchange 18 second-hand automobiles formerly used by the Venereal Disease Section for eight new cars. Passed.

Dr. Ball reported that reduction in fees for orthopedic surgeons would definitely affect the Crippled Children's program unfavorably. He requested that the Executive Committee hold in abeyance its previous instruction to reduce the fees for orthopedic surgeons. It was moved by Dr. Hanckel, seconded by Dr. Barron, that the reduction of fees of orthopedic surgeons be postponed provided the budget be not exceeded, until Dr. Ball can make an investigation of all factors involved and report back to this Committee. Passed.

It was moved by Dr. Barron, seconded by Dr. Hanckel, that the attached appreciation of Dr. Wyman be approved by the Executive Committee, entered in the minutes of this Committee, and copies sent to the family of Dr. Wyman and to the Journal of the South Carolina Medical Association. Passed.

It was moved by Dr. Barron, seconded by Dr. Hanckel, that physical examinations be required of all new employees of the State Board of Health. Passed.

NEWS

PHYSICIAN DRAFT

For the first time in 16 months, the Army is scheduled to call up a group of physicians under the doctor draft. The Defense Department late in August instructed Selective Service to call up 550 physicians for induction in December. The department said 100 are required for the Army, the first draft since August, 1953; 250 for the Navy; and 200 for the Air Force. In addition, the Air Force will require 150 dentists. the first to be called since last May. Officials indicated that the physicians to be drafted would be drawn from priorities 1 and 2 and, to some extent, from priority 3.

—J. A. M. A.

Dr. C. G. Hoppers, Jr., Gaffney, S. C., this week opened his office for the practice of medicine in the office formerly occupied by Dr. Carl Parker in the Herbert Smith building over Clover Drug Store, at Clover.

Dr. Robert J. Schmoll opened his office in Greenville on July 1, 1954. He is limiting his practice to ophthalmology.

Dr. Foster N. Martin, native of Newberry, has returned to Newberry as general practitioner in medicine. Dr. Martin prior to returning was on the staff at Tulane University, New Orleans, La.

Dr. John A. Siegling, professor of orthopedic surgery at the Medical College of South Carolina, spoke before the Greenville County Medical Society in August.

The meeting was held at Shriner's Hospital for Crippled Children, which has played host to the society at its August meeting each year for about 15 years.

H. M. Allison, M. D. and L. N. Bellew, M. D. announce their association in the practice of obstetrics and gynecology at 907 Pendleton Street, Greenville, South Carolina

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Lewis J. Moorman, M. D., will be long remembered by his colleagues and former students, as well as all who have read "Pioneer Doctor"—the account of his own early experiences. His death on August 2, 1954, terminates 15 years of service as the Editor-in-Chief of the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION.

Dr. Ruth Smith Johnson opened her office for the practice of Pediatrics on August 18 at 506 West Palmetto Street in Florence.

Dr. Tom. J. Lattimore, general surgeon, has set up offices at 809 Lancaster Street in Aiken.

Dr. R. H. Hand, an obstetrician and gynecologist, has opened his office in the McWhorter Building on North McDuffie Street, Anderson.

Dr. E. H. Reeves, Jr. has opened offices for the general practice of medicine and surgery in Laurens.

Dr. H. LeRoy Brockman of Greer, has formed an association for the practice of general surgery with Dr. L. G. Able, of Spartanburg, with offices in The Wellington, 349 East Main Street.

Dr. C. H. Haynsworth recently assumed his duties in association with Dr. Lamar Lee and Dr. Frank Lee at Saunders Memorial Hospital in Florence.

Dr. Robert C. McLane of Pelzer and Greenville will practice in Belton, associated with Dr. K. M. Waggett.

Dr. E. G. Norwood, of Bennettsville has become an associate in the practice of general medicine with Dr. Frank L. Martin, in Mullins.

Dr. Thomas E. Fulgham, of Augusta, an eye, ear, nose, and throat specialist, announced that he will establish practice in Bamberg.

Dr. Harry S. Allen, Jr., a native of Florence, has opened an office for the practice of internal medicine at 248 S. Irby Street.

Dr. C. P. Ryan, Jr., has arrived in Ridgeland and is engaged in the practice of medicine. He has remodeled and furnished offices for himself in the Ryan Building on Main Street.

PEE DEE MEDICAL MEETINGS

Note: All Meetings Are Held On The Third Thursday.

October 28 — Florence—ANNUAL MEETING—Speakers to be announced.

November 18—Chesterfield—Barbecue and Atomic Medicine: speaker, Dr. G. A. Andrews, Clinical Director of the Medical Department, Institute of Nuclear Studies, Oak Ridge, Tenn.

December 16 — CHRISTMAS PARTY AND LADIES NIGHT—Joint effort of Association to be held in central location to be announced. Dinner Dance, floor show, corsages, favors.

Dr. M. W. Beach was elected State Chairman of the South Carolina Chapter of the American Academy of Pediatrics on September 14.

DEATHS

DR. A. P. McELROY

Dr. A. P. McElroy, 78, prominent Union physician, died at his home on August 10, after a one year illness.

Dr. McElroy was a graduate of The Citadel and the Medical College of South Carolina at Charleston, serving his internship at Roper Hospital.

He moved to Union in 1909 where he first started practice of medicine. Dr. McElroy served in World War I as a captain and saw duty in France. He was past president of the Association of Surgeons of the Southern Railway, past commander of the American Legion, chairman of the commission of Public Works and a trustee of the Union Carnegie Library.

DR. GARDEN CLARKSON STUART

Dr. Garden Clarkson Stuart, 76, of Eastover died on August 24 in the Columbia Hospital.

Doctor Stuart was born in Washington, D. C., May 14, 1878, the son of the late Rev. Albert Rhett Stuart and Sophie Clarkson Stuart.

He was a life time resident of Richland county and was a member of Zion Episcopal Church. Doctor Stuart was an honorary member of the Medical Association and had practiced medicine in Eastover for more than 45 years.

DR. WILLIAM JOEL PERRY

Dr. William Joel Perry, 76, physician of Chesterfield, died on August 28.

Doctor Perry was in declining health since he suffered a coronary thrombosis in 1943. Death came from a paralytic stroke.

Doctor Perry was born in Union County near Wingate, N. C. In 1900, he was graduated from the Atlanta College of Physicians and Surgeons, now Emory University, in Atlanta, Ga.

In 1906-07 he continued the study of medicine and surgery at the New York Polyclinic. Upon graduation from Emory, he settled in the Taxahaw community, near Lancaster, and began the practice of medicine.

He took an active part in the life of the community, as a member of the Baptist Church, superintendent of the Sunday school and as a Mason. In 1909, at the request of a number of prominent citizens of Chesterfield, he moved there, and for more than 40 years continued to serve the people of that county as physician, legislator and friend.

DR. WILLIAM BOYKIN LYLES

Dr. William Boykin Lyles, 77-year-old prominent Spartanburg physician died September 11.

Doctor Lyles, a Fairfield County native, was past president of the Tri-State Medical Association and the Urological Association of South Carolina.

The son of the late John Woodward and Susan Morris Lyles, he attended South Carolina College (the University of South Carolina) was graduated from the Medical College of Virginia, practiced medicine at Georgetown, moving to Spartanburg in 1907 where he did general practice several years.

After a year's post-graduate work at John Hopkins and at Post-Graduate Hospital at New York City, he returned to Spartanburg and did urological work exclusively, pioneering in this speciality in the Piedmont Carolinas.

BOOK REVIEWS

PLANNING FLORIDA'S HEALTH LEADERSHIP by Russell S. Poor, Ph.D., Univ. of Florida Press, Gainesville, 1954. Price $1.50.

Russell S. Poor, Ph.D., Provost, The J. Hillis Miller Health Center, has written an informative brochure, emphasizing the fact that the extension and improvement of medical facilities have not kept pace with the rapid growth of population; and that in Florida, as in other states, the need for doctors has become increasingly acute.

This publication is one of the Medical Center Study series that have been issued following a mandate of the 1949 Legislature, that a Medical School and a School of Nursing be established at the University of Florida. A university faculty committee of twenty was asked to outline a research study which would chart a course of action for the functioning of the two schools within the framework of the University.

Following a foreword, and introduction, the summary discusses the following items:

1. Florida's Need for Medical and Related Education.
2. Florida Center of Clinical Services: Interdepartmental Cooperation.
3. Medical Education in a University Setting.
4. Health Center Units.
5. Southern Regional Implications and Inter-American Relationships.
6. Administration, Personnel, Finances, Time Schedule and Principal Recommendations.
7. Recent Developments. A brief bibliography of medical education, and related fields, completes the summary.

The summarized Medical Center Study presents a framework for a program designed to train the necessary leadership for the improvement of health of the people of Florida and the surrounding region.

Twelve items are discussed which include a recommendation to plan schematically a completely integrated building to house all parts of the Health Center: a College of Medicine, a College of Nursing, a College of Pharmacy, a College of Dentistry, a University Teaching Hospital, an Auditorium, and a lodging unit for patients requiring prolonged diagnosis and treatment.

The study also recommended that various means of cooperation be undertaken in a program of education and service with state and federal Health and Welfare Agencies, and also to outline ways in which the University of Florida Health Center may contribute to the improvement of medical education and the betterment of health throughout the southern region; and to analyze the significant medical needs of middle and South American countries and to suggest ways in which the University Health Center may cooperate with these countries.

The Summary represents a group of practical suggestions, which may well serve as a blue print for health leadership, not only in Florida, but in other places, where there is an evident shortage of physicians and a lack of proper teaching facilities.

Leon Banov, M.D.

ILLUSTRATIVE REVIEW OF FRACTURE TREATMENT by Frederick Lee Liebolt—Lange Medical Publications, Los Altos, California—1954. Price $4.00.

This is an excellent treatise of fracture treatment in a very brief and readable form.

Dr. Liebolt begins with the anatomy and physiology of bone giving the essential data in a concise manner that can be reviewed very easily. His illustrations throughout the book are excellent both from the point of view of the type of injury sustained as well as the causative agent.

This book is heartily recommended for medical students and house officers, however, it is this reviewer's opinion that much of the treatment is made to look much more simple than it actually is. It is hoped that the general practitioner will not read the book and feel that complicated fractures are easy to treat.

S. Edward Izard, M.D.

BEYOND THE GERM THEORY, The Roles of Deprivation and Stress in Health and Disease by Iago Galston, M.D., A New York Academy of Medicine Book, Published by Health Education Council, 10 Downing Street, New York, 14, New York. Price $4.00.

The title of this book suggests that a new theory is to be expounded, while in reality the several papers included stress the fact that many factors other than infection are of major importance in the consideration of morbidity in practice and in public health. The book is in the nature of a sequel to "The Epidemiology of Health." The concept of "homeostasis" and the importance of stress of various kinds are outlined in an interesting manner, and the idea is offered that these important factors are possibly often neglected because of too much concern with germs and their toxins.

Some of the material is in the nature of a summary of well recognized facts and concepts, and tends to emphasis rather than to revelation. Perhaps to many readers the concept of deprivation, physical and emotional, as stress will be rather unusual, but obviously fitting.

Nutritional deprivation, the stress of pregnancy and its effect on the infant, psychological deprivation and stress at all ages, especially in infancy, and other related matters are discussed by a number of eminent authorities.

There are some statements which are a little hard to accept, such as the remark that 75% of women rejected the fact of pregnancy in the first trimester, and only a third had been reconciled by the third trimester. The source of such information must have been an unusual group or the circumstances must have been exceptional. Is it the biological fact or the economic or social implications which are rejected? A chapter on the serious effects of emotional deprivation in infants in a nursery and in a foundling home expounds in more scientific manner a fact that every good pediatrician has long known, viz; that TLC ("tender loving care," to the uninitiated) is a vital ingredient in all treatment.

This reviewer stumbled over a few unfamiliar words in this very good book. Especially at his age was he concerned with *geron*, probably a well accepted term, but alas, only two letters removed from *moron*.

J.I.W.

Give the United Way!

MEDICAL COLLEGE OF SOUTH CAROLINA

Tentative Program For
Post-Graduate Seminar and Founder's Day

November 2-4, 1954

Tuesday (November 2) A. M.

8:30 Registration and Greetings
9:00 A Case Report—Dr. W. E. Ector
10:00 Tetanus—Dr. M. W. Beach and Dr. Margaret Q. Jenkins
11:00 A Case Report—Dr. Wm. B. Gamble, Jr.
12:00 Diarrhea—Dr. J. R. Paul, Jr.

Tuesday P. M.

2:00 Management of Cardiac Arhythmias—Dr. R. M. Anderson
3:00 Treatment of Hyperpotassemia—Dr. Vince Moseley
4:00 Therapy with Streptococcic Enzymes—Dr. C. deSaussure
5:00 Chronic Arsenic Poisoning—Dr. Robert Wilson

Wednesday (November 3) A. M.

9:00 The Diagnosis and Treatment of Genital Infections—Dr. J. R. Sosnowski
10:00 Abortion—Etiological Factors and Treatment—Dr. Fraser Wilson
11:00 Medical Complications of Pregnancy—Dr. James M. Wilson
12:00 The Diagnosis and Treatment of Eclampsia—Dr. L. L. Hester, Jr.

Wednesday P. M.

2:00 Nerve Blocks for Relief of Pain in Advanced Cancer—Dr. John Brown and Dr. F. E. Kredel
3:00 Acute Gastro-Intestinal Hemorrhage—Dr. Henry W. Mayo, Jr.
4:00 Local Treatment of Burns—Dr. Robert F. Hagerty
5:00 Hydrocortisone Injection of Joints and Bursae—Dr. R. M. Paulling
7:00 Buffet Supper and Roundtable Discussion

Founders' Day—Thursday—November 5

8:30 Registration & Greetings
9:00 Emergency Conditions of the Newborn Infant—Dr. McLemore Birdsong, Asso. Professor of Pediatrics, University of Va.
10:00 Renal Deficiency Associated with Secondary Shock—Dr. Virgil H. Moon, Research Professor of Pathology, University of Miami
11:15* Some Aspects of Cancer Research—Dr. William E. Smith, New York University—Bellevue Medical Center
12:15 The Rheumatoid Arthritic Cripple: Total Rehabilitation—Dr. Edward W. Lowman, New York University—Bellevue Medical Center
1:30 Lunch—Medical College: Alumni Memorial House
2:30 Dedication Exercises of Alumni Memorial House
3:30 Inspection of Dormitory

*At 11:00 Coffee Break: Alumni Association, School of Nursing

PRESIDENT'S PAGE

Though the re-insurance plan of President Eisenhower and Mrs. Hobby was defeated during the recent session of Congress, it is evident that this Administration is more liberal than we first thought in reference to so-called "social medicine." It is to be remembered that both the above-named bill and the inclusion of physicians under the social security scheme would have been passed had it not been for the active opposition of the medical profession. It now appears that no matter whether the Administration of this country is in the hands of the Republicans or the Democrats the medical profession must carefully scrutinize all bills introduced in Congress which have a bearing upon us.

While voluntary insurance plans and better public relations are of importance, it would appear that our most effective antidote against socialized medicine lies in the hands of the individual practitioner. If each American citizen might have a family physician and medical advisor to whom he knows he can turn when he or members of his family are ill; on whom he knows he can depend for treatment; that the cost of such treatment shall be within reason in proportion to his income, then socialized medicine will cease to be a factor in this country. If each call from a layman to any physician in America is answered in a tactful and diplomatic way and if every effort is made by the physician or his representative to see that that call is taken care of either by the physician called, by one of his confreres, or possibly seen temporarily by a registered nurse who represents him, the proponents of socialized medicine will have lost their appeal to the public.

Plans are progressing for the meeting in Charleston during the second week in May of 1955 and most of the out-of-state speakers have already been obtained. The Scientific Program Committee is doing an excellent job and the meeting should be one of the best.

Tom Gaines

ANNOUNCEMENTS

Invitation To All South Carolina Physicians To Attend

FOURTH ANNUAL MEETING
SOUTH CAROLINA CHAPTER AMERICAN COLLEGE OF SURGEONS

Columbia Hotel

Columbia, South Carolina

Friday and Saturday—October 29th and 30th, 1954

Registration and "get-togethers" Thursday Evening October 28th.

Ladies: Registration and Lounge Room—Columbia Hotel.
"Coffee' and Fashion Show — Friday, October 29th, 11:30 A. M.
Banquet and Dance—Friday Evening, October 29th.
Football Game—U. S. C. vs. Maryland—Saturday Afternoon, October 30th.

PROGRAM

Friday, October 29th

8:30 A. M. Registration—Mezzanine, Columbia Hotel
Empire Room—Columbia Hotel
Presiding: Austin T. Moore, M. D., F.A.C.S., Columbia, S. C.
President S. C. Chapter American College of Surgeons

9:15 A. M. Welcome—David F. Adcock, M.D., F.A.C.S., President Columbia Medical Society

9:20 A. M. "A New Technique in Varicose Veins Surgery"
Richard S. Wilson, M. D., Spartanburg, S. C.

9:40 A. M. "Use of Sutures in Cataract Extraction"
David S. Asbill, M.D., F.A.C.S., Columbia, S. C.

10:00 A. M. "The Present Status of the Surgical Treatment of Lesions of the Stomach"
William F. Rienhoff, Jr., M.D., F.A.C.S., Associate Professor of Surgery, Johns Hopkins Hospital, Baltimore, Maryland.

10:45 A. M. "Abdominal Pregnancy"
Heyward H. Fouché, M.D., F.A.C.S., Columbia, S. C.

11:05 A. M. "The Vaginal Approach To Pelvic Pathology"
F. Bayard Carter, M.D., Professor of Obstetrics and Gynecology, Duke University Hospital, Durham, North Carolina

11:50 A. M.—"Some Experiences with Surgery of Intracranial Aneurysms"
William H. Bridgers, M.D., F.A.C.S., Columbia, S. C.

12:10 A. M. "Subarachnoid Alcohol and Other Types of Block for Relief of Pain in Advanced Cancer"
John M. Brown, M.D., Charleston, S. C.
Jennings K. Owens, M.D., Bennettsville, S. C.
Frederick E. Kredel, M.D., F.A.C.S., Charleston, S. C.

12:30 A. M. Adjournment for lunch.

1:00 P. M. Luncheon and Business Meeting—Fellows of the American College of Surgeons, State Room, Columbia Hotel
Guest Speakers:
Peter B. Wright, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgia Medical College, Augusta, Ga., Governor Southeast District, American College of Surgeons.
David Henry Poer, M. D., F.A.C.S., Associate Professor of Surgery, Emory University Medical College, Atlanta, Ga., Past Governor American College of Surgeons

2:30 P. M. "Controversial Points in the Diagnosis and Treatment of Lesions of the Skeletal System"
Bradley L. Coley, M.D., F.A.C.S., Attending Surgeon in Charge of Bone Tumor Department, Memorial Hospital for Treatment of Cancer and Allied Diseases, New York City

3:15 P. M. Panel Discussion: "Diseases of the Thyroid Gland"
William H. Prioleau, M.D., F.A.C.S., Charleston, S. C.—Moderator
William F. Rienhoff, M.D., F.A.C.S., Johns Hopkins—Guest Surgical Panel Member
O. B. Mayer, M.D., F.A.C.P., Columbia, S. C.—Guest Medical Panel Member
John C. Hawk, M. D., F.A.C.S., Charleston, S. C.—Surgeon in Charge Isotope Laboratory, Medical College of South Carolina

3:15 P. M. Panel Discussion: "Obstetrics and Gynecology" F. Bayard Carter, M. D., Professor of Obstetrics and Gynecology, Duke Univ. Hospital, Durham, North Carolina

4:15 P. M. Panel Discussion: "Bone Tumors"
Austin T. Moore, M.D., F.A.C.S., Columbia, S. C.—Moderator
Bradley L. Coley, M. D., F.A.C.S., New York City—Guest Surgical Panel Member
Oscar L. Miller, M.D., F.A.C.S., Charlotte, N. C.—Guest Orthopedic Panel Member
Henry Potozky, M.D., Chief of Radiology, Vet. Adm. Hospital, Columbia, S. C.—Guest Radiological Panel Member
Henry A. Plowden, M.D., Pathologist Columbia Hospital Columbia, S. C.—Guest Pathologist Panel Member

5:15 P. M.—Adjournment

7:30 P. M.—Cocktails—
Empire Room, Columbia Hotel (Black tie preferred—Ladies invited)

8:00 P. M.—Banquet—
Greetings: Thomas R. Gaines, M.D., F.A.C.S., —President South Carolina Medical Association
Speaker: Dr. Donald Russell — President University of South Carolina
Dance—Special Entertainment

Saturday, October 30th

8:00 A. M.—Operative Clinics:
Columbia Hospital, S. C. Baptist Hospital, Providence Hospital

9:30 A. M. Empire Room—Columbia Hotel
"Acute Calcific Tendonitis"
John A. Siegling, M.D., F.A.C.S., Charleston, S. C.

9:50 A. M. "Diagnosis of Kidney Tumors"
Wallace D. Cone, M. D., Sumter, S. C.

10:10 A. M. "Side Actions of Anesthetic Agents"
Lester Rumble, Jr., M.D., Director of Anesthesiology, St. Joseph's Infirmary, Atlanta, Ga.

10:40 A. M. Panel Discussion: "The Treatment of The Burned Patient"
Auspices of American College of Surgeons—S. C. Chapter, Committee on Trauma
Lawrence H. McCalla, M.D., F.A.C.S., Greenville, S. C.
Chairman of the South Carolina Committee on Trauma—Moderator
Cecil G. White, M.D., F.A.C.S., Greenville, S. C.
Robert F. Hargarty, M.D., Charleston, S. C.

11:40 A. M. Adjournment

2:00 P. M. Football Game U.S.C. Vs. Maryland —Special Reserved section on 50 yard line for Doctors attending meeting.

(Tickets may be secured by writing directly to The University of South Carolina)

TRIBUTE TO DR. WILLIAM ATMAR SMITH

At the meeting of the Charleston County Medical Society on November 9, 1954 at 8 P. M. a bronze plaque with a profile of Dr. William Atmar Smith, former President of the South Carolina Medical Association, will be presented to Pinehaven Sanatorium. This plaque has been made possible by funds contributed by Dr. Smith's medical friends. The sculpture is by Willard Hirsch of Charleston.

The medical friends of Dr. Smith are invited to attend.

THE MONTH IN WASHINGTON

Washington, D. C.—When the 84th Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the federal government set up a system for reinsuring health insurance programs. He declared: "Health reinsurance we are going to put before Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. AMA's position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the program projected the federal government too far in the direction of control of medical care.

Later in the session, Mr. Eisenhower himself and Mrs. Hobby made every effort to win over critics of reinsurance, and to force the bill through Congress. In the light of these efforts—including a nationwide radio appeal by Mrs. Hobby—the defeat of the bill in the House of Representatives was regarded as one of the most surprising suffered by the Administration on any domestic legislation.

Currently Secretary Hobby and Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee are attempting to bring together all parties interested in health legislation to see if a compromise can be worked out on reinsurance.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for action, but the introduction of the House bill was held up until Defense Department could estimate the first year's cost, eventually set at $67 million. At any rate, neither Senate nor House Armed Services Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents . . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional committees, it has made its views known to the Defense Department. In general the AMA is not opposed to Defense Department proposals that a more uniform system be worked out, and that the federal government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by Congress. Basic state allotment percentages have been worked out for the new Hill-Burton program (for facilities other than complete hospitals) and for the expanded vocational rehabilitation program. The Internal Revenue Bureau is about to issue detailed instructions to taxpayers regarding changes in medical expense deductions and other benefits in the new tax law.

—AMA Washington Office

The largest and most widely instructive meeting of surgeons in the world, the 40th annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, New Jersey, November 15 to 19. More than 10,000 Fellows of the College and their guests from all over the world will gather to fulfill the purposes of this Congress: to discover, to inform and to learn. This postgraduate education meeting will present recent surgical developments through a wide variety of programs, including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television and exhibits. Dr. Charles deT. Shivers, Atlantic City, is Chairman of the Atlantic City Advisory Committee on Arrangements.

Dr. Frank Glenn, New York, current President of the American College of Surgeons, will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Blalock, Baltimore, will be installed as President for the coming year.

Dr. Evarts A. Graham of St. Louis is Chairman of the Board of Regents and Dr. Paul R. Hawley of Chicago is The Director.

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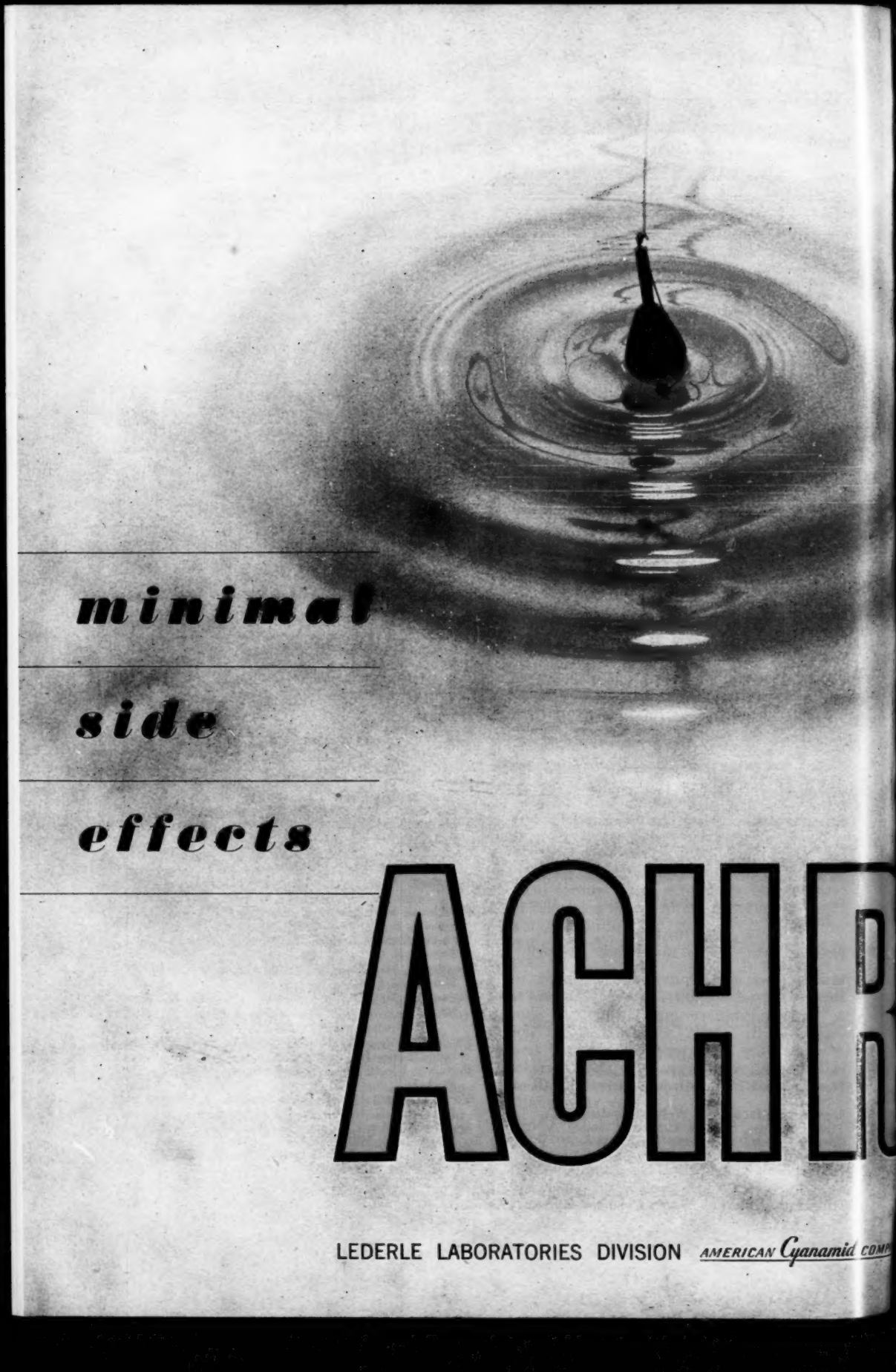
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PEE DEE AUXILIARY AWARDS THREE SCHOLARSHIPS TO STUDENT NURSES

Since the James McLeod Memorial Scholarship awarded annually by the Pee Dee Medical Auxiliary had not been used for three years the executive board decided to award three scholarships this fall. Recipients of this aid are Shirley Ganey of Rockingham, N. C., Jarma Jean Chewning of Manning and Beverly Ann Carter of Manning. These awards were based on scholastic record and financial need. All three girls are freshman students at the McLeod Infirmary School of Nursing. They were presented to a group of Auxiliary members at an informal Coca Cola party in the library of the McLeod Infirmary recently. The Auxiliary is indebted to Miss Rita Smith, director of nurses, and Mrs. Bertie Stokes, nurse recruiting officer for the hospital for their assistance in selecting worthy girls.

VFW AUXILIARY AWARDS NURSING SCHOLARSHIP

Miss Rachel Borkowitz of Scranton has been chosen by the Veteran of Foreign Wars Auxiliary for a full three-year term scholarship at McLeod Infirmary School of Nursing. Mrs. Hazel Wells, president of the Florence Auxiliary, made the presentation Tuesday, July 27, in the library of the hospital. Miss Borkowitz, a daughter of Mr. and Mrs. J. A. Borkowitz, graduated from Lake City High School. The admissions committee took into consideration for their judging of a list of possible candidates the worthiness of the case, scholastic rating and membership of a member of the immediate family in the U. S. Armed forces. Miss Borkowitz has a brother who is serving with the U. S. Navy, presently stationed in the Mediterranean.

"A FAMILY DOCTOR IN EVERY DOCTOR'S FAMILY"

This resolution was adopted at the annual convention of the Woman's Auxiliary to the American Medical Association and we reprint it here feeling that it is of vital interest to every doctor's wife.

WHEREAS, The health needs of the American people can adequately be met only if there is ample number of able and efficient practitioners of medicine, and

WHEREAS, The health of America's doctors is thus a matter of grave concern not only to the individual doctors, their families, and the entire medical profession, but to the public as well, and

WHEREAS, It is a well recognized and deplorable fact that the physician is often the last one to heed advice he urges upon his patients and thus often goes without periodic examinations or without the advantage of a personal physician who maintains an accurate health record of the individual physician and the members of his family, and

WHEREAS, Failure to heed his own advice, and failure to employ the services of a family physician for himself and his family may be directly related to the fact that the average expectancy of physicians in America is appreciably lower than the average expectancy of males generally, and

WHEREAS, The members of a physician's family are deprived of adequate and proper medical care if they resort to first one and then another of the physician's medical colleagues with no single individual filling the role of a personal physician for the family and maintaining a continuing health record for each member of the family and

WHEREAS, The American Academy of General Practice, at the instigation of its late vice-president, Dr. Merrill Shaw of Seattle, has launched a program to persuade every physician in America to select a regular family physician for himself and his family, and

WHEREAS, This program, which has attracted wide-spread attention in newspapers and popular magazines, is setting an important precedent for the lay public, which, if followed, will improve the nation's health and simultaneously the goodwill enjoyed by the Medical Profession, now, therefore, be it

RESOLVED, That the Woman's Auxiliary to the American Medical Association commends the American Academy of General Practice for its meritorious efforts in the furthering of this worthy project, and be it further

RESOLVED That the Woman's Auxiliary to the American Medical Association hereby endorses the Academy's project and urges every member of the American Medical Association to support the program and co-operate in it by taking upon himself the responsibility of designating a physician to serve as family physician for his family, thus setting a prime example of good health practice for his patients and the people of his community.

W.M.A. NEEDS IMMEDIATE FINANCIAL SUPPORT. Doctors who are members of the United States Committee of the World Medical Association now are receiving letters, citing the present financial plight of the W.M.A. and urging immediate financial support to build up a depleted treasury.

In an urgent appeal from Dr. Louis H. Bauer, secretary-treasurer of the U. S. Committee, members are being asked to talk about the W.M.A. to their friends and sign them up. The membership fee is only $10.

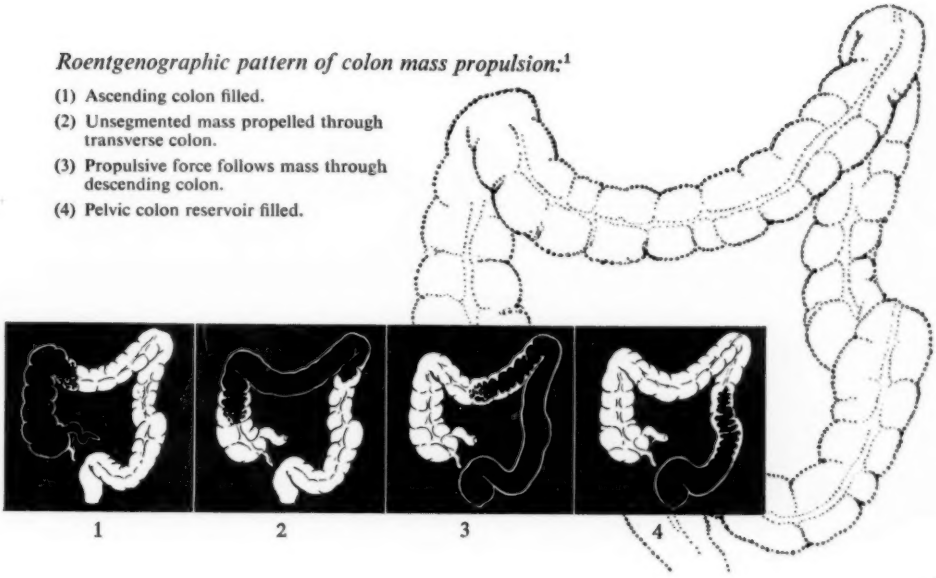
"At the moment," Dr. Bauer said in a note to me, "we do not have sufficient funds either to handle the General Assembly or run the association for another year."

Since its founding in 1947, the W.M.A. has earned increased respect from international governmental organizations.

"But," as Dr. Bauer says, "there is a constantly growing tendency for decisions affecting all of medicine to be made at the international level. This tendency is a threat not

Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.
(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

only to the future of medicine itself, but to the rights and privileges of every practicing physician. One example is the current attempt of incompetent organizations to draft a Code of International Medical Law which would affect all physicians in peace as well as in war. The World Medical Association is the only international organization which can and does speak from the non-governmental standpoint and from the standpoint of free enterprise. However, it can only continue to defend your interests if it has adequate financial support."

Dr. Bauer explained that W.M.A. support from industry as a whole has decreased this year and the campaign to increase individual membership in the U. S. Committee "has not been as successful as we had hoped."

Consequently, he is asking doctors all over the country to join in a renewed membership campaign. Application blanks can be secured from Dr. Louis H. Bauer, World Medical Association, 345 East 46th Street, New York 17, N. Y.

In spite of the fact that this country is considered one of the most civilized nations in the world—it is still the victim of a conversational taboo—the toilet. And judging from a survey conducted in the interest of Jonny Mop, a deodorizing, thorough disposable toilet mop, it was found that the taboo also extended to a form of *blindness* where this area of housekeeping is concerned. Modern woman has taken advantage of every appliance that has been waved in front of her—and what she hasn't encountered in modern equipment she has developed herself . . . . but in the matter of complete bathroom hygiene she has pursued the ostrich-in-the-sand view, according to the Jonny Mop survey. Women are apparently uneducated to the dangers of toilet germs in their own home—and while they use every precaution in public washrooms they are utterly unaware of the dangers lurking in their own bathroom . . . . because they obviously don't care to pursue a subject for which they have no natural appetite.

Out of 141 homes visited, and these ranged from medium low income brackets where bathrooms are only common to the very high where they are acutely luxurious, each one of the housewives maintained that the bowl in her bathroom was cleansed daily and could be considered only a paragon of cleanliness.

At a glance this attitude seemed an accurate appraisal . . . . but when the subject of the lip of the bowl (which protrudes some two or three inches and is seldom seen) was discussed with the lady of the house or the maid, 139 out of 141 confessed ignorance as to how to handle the problem it housed.

Underneath the lip or rim, streams the water which flushes waste material, and over the lip is the toilet seat. "Do you, Madam," the questioner asked, "ever clean under the lip"? 139 out of 141 answered "no". Most of them contended it didn't seem necessary. When the survey group lifted the seat and a mirror was held so that it reflected the condition underneath the lip, the sensitive ladies were aghast. In every case there was a three to five inch yellow band of discoloration.

When a prominent laboratory (Associated Analytical Laboratory) swabbed this area in various houses, the results were cogent. The laboratory technician rubbed a sterile cotton swab underneath the rim of the bowl. He then went over the identical area with a Jonny Mop, so created that it contacts every accessible area with a soapy sanded deodorizer and cleanser that whitens the rim as it discourages the bacteria . . . . then by pressing a tiny button in the handle the detachable tissue that did the cleansing is flushed away. The laboratory technician then swabbed it with sterile cotton to ascertain the bacterial count before and after, and calculated the percent of reduction. In one home, in the mid-town Murray Hill section of New York City, the bacteria count over a 24 hour period at 37 degree Centigrade, before being Jonny Mopped, was 3,648,000. After use of the Jonny Mop the percentage reduction was 44.25%. In a home on the upper East Side by using the Jonny Mop, percent reduction was 17%. On the upper West Side the tests revealed a bacteria content of 162,000. The percent reduction ran to 92%.

The report commented that wiping an area of a toilet bowl with a Jonny Mop apparently reduced the numbers of the viable bacteria, and the samples taken were representative.

Only 6 of the 141 women interrogated suspected the possible presence of such dangerous odor-producing and health-hazard organisms as:

Escherichia coli
Aerobacter aerogenes
Streptococcus faecalis hemolytic streptococci of Lancefield's Group D
Micrococus pyogenes var. albus
Micrococus pyogenes var. aureus
Clostridium perfrigens (gas gangrene)
Clostridium putrificum
Clostridium sporogenes
Clostridium tetani (tetanus)
Lactobacillus acidophilus
Lactobacillus brevis
Bacteroides sp. (have been found in mixed infections of the gastro-intestinal tract)